HEALING FRACTURED LIVES

How Three School-based Projects Approach Violence Prevention and Mental Health Care

Bureau of Primary Health Care

THE PEOPLE WE SERVE... THE PEOPLE WE ARE

U.S. Department of Health and Human Services
Public Health Service
HRSA
Health Resources & Services Administration

The HRSA BPHC would like to thank Leila Fiester and Sara Nathanson for their authorship of this publication.

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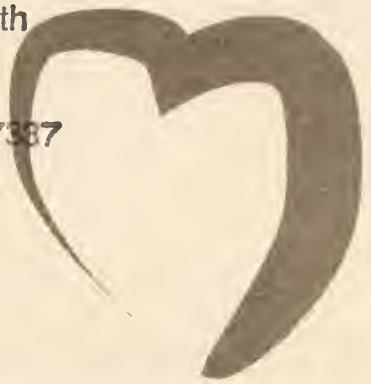

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BUREAU OF PRIMARY HEALTH CARE

Public Health Service

Health Resources and
Services Administration
Bethesda MD 20814

June 1, 1996

Dear Colleague:

The Health Resources and Services Administration's Bureau of Primary Health Care is proud to present you with this publication entitled Healing Fractured Lives: How Three School-based Projects Approach Violence Prevention and Mental Health Care.

The three programs profiled in this book have developed innovative ways to improve access to primary care, particularly mental health and violence prevention services, through the school-based health center.

There are many individual and personal success stories presented in Healing Fractured Lives. The school-based setting offers numerous opportunities to implement exciting programs that address the health care needs of vulnerable children and youth. These three programs have a great deal of experience and advice to offer other health care providers interested in establishing or expanding mental health services in the schools. We hope that, through this publication, you will benefit from their leadership.

We are pleased to share with you these models of school-based mental health and violence prevention services. We hope that you will apply some of the ideas and tips from the field in your own community.

Sincerely yours,

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Director

Enclosure

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Project leaders and staff, health clinic administrators and practitioners, principals, teachers, school nurses and counselors, parents, students, law enforcement officials, evaluators, and many other participants at the three pilot projects were vital resources for this report. During site visits and telephone interviews, they contributed their time and candid insights so that other communities and schools might benefit from what they have learned. The authors would like to thank Ann Anderson, Carolyn Brown, Jennifer Butts, Jose Cardenas, Chis Campbell, Celeste Chan-Wolfe, Patrick Crouse, Fran Donelan, Cassandra Edwards, Judith Glass, Michael Godfrey, Sam Grasso, Debbie Grimes, Ernest Halterman, Gerry Hill, Tremaine Joel, Chris Kilbourne, Kimberly Kent-Wyard, Mary Ann Knott, Jan Komarenski, Jan Marquard, John Miller, Elisa Mogul, Brian Moranio, Tonja Ringgold, Arlene Rosenblat, Philip Saldivar, Elnora Saunders, Elizabeth Snapp, Lucy Soloman, Ann Starnes, Donna Strawderman, Mary Taylor-Ennis, Joyce Teets, Lhanjay Tempo, Shelba Vincell, Barbara Vogel, Patricia Waters, Melissa Weddle, Carol Whetzel, Steve Wilson, and Peggy Wright.

Table of Contents

Executive Summary

Health providers and educators agree: Violence in communities and homes across America undermines children's health, mental health, readiness to learn, and ability to stay in school. Many health and education practitioners also agree that school-based violence prevention services can counteract these effects by offering children access to mental health care and by teaching practical skills in conflict resolution and violence avoidance. This report synthesizes the lessons learned at three sites that used special grants from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA BPHC) to plan, design, and implement school-based violence prevention/mental health services. Although the sample of sites was small and diverse, and this study did not verify each site's conclusions through evaluation, certain tentative findings suggested by our sources may be relevant to other sites considering similar projects. These impressions address planning, designing, implementing, and sustaining school-based violence prevention projects.

Planning Issues

- **Ideally, school-based clinics should incorporate mental health care from the beginning of clinic implementation.** Many school-based health projects focus initially on medical issues and add mental health care later, when the clinic is firmly established or the clinic obtains additional funding. As several sources noted, this delay can leave school staff, health providers, and students without the resources they need. "You don't want a good practitioner in here finding problems and having nowhere to go for help," said one clinic administrator. "There's a tendency to think of mental health as secondary—but it is just as important [as other medical services], if not more so."

- **When violence-prevention or mental health efforts are added to schools after other health care services, the preexistence of a school-based clinic facilitates mental health efforts.** A school-based clinic's acceptance by the school and community smoothes the way for counseling services, which otherwise can seem intrusive or threatening to some parents and school staff. At one site in our sample, attempts to expand mental health services to a second school that lacked a school-based clinic failed in part because the abruptness of the counselor's introduction into the school, combined with her lack of experience working in schools, generated resistance from school staff. The same site succeeded in introducing mental health counseling to two schools that already shared support for an on-site clinic.

- **Children should be exposed to school-based mental health/violence prevention efforts from an early age.** Sources at all of the projects in our sample said that violence prevention efforts should not be delayed until middle or high school. Especially in inner cities, children are exposed to violence from a very early age, and many boys begin their experiences with guns and gangs in elementary school. "By middle school, they've seen murders, and they've probably been involved," a school-based clinic psychologist said. Because these reactions to violence are deeply

embedded by middle school, projects that target older children must dismantle unhealthy behaviors and defuse immediate crises before they can focus on preventive measures. Several sources recommended introducing conflict resolution concepts, in an age-appropriate manner, as early as kindergarten.

• **Expanding a school-based health center to include more mental health services requires time and a forum for all stakeholders to buy into the concept, especially when mental health care providers are not district personnel.** Every source at every site told us the same thing: *You must allow adequate planning time to involve as many stakeholders as possible–mental health and health providers, teachers, principals, school district personnel, health administrators, parents, and even students—in order to build the investment and "buy-in" that will support integration, coordination, and collaboration among the school, health clinic, families, and community.* In the rush of planning, it isn't easy to find time to gather a broad planning group, or to establish a forum in which many players can help define the new project, but the resulting support is worth the struggle.

Design Issues

• **The educational components of violence prevention are as important as mental health services but tend to be less developed because clinics must focus limited time, resources, and staffing on crisis intervention.** Mental health providers and educators alike observed that students do not understand the nature of violence—let alone how to prevent it. Psychologists at one site strongly recommended including an educational component that teaches students what violence is, how it is perpetrated, and what the consequences are—what it means to be hurt. "[Students] see violence so much it's a way of life," said one. "We need to show how families and communities are affected....Kids don't understand [that] there's emotional and mental pain involved." For example, a violence education project might include role playing and exposure to other children who have been hurt by violence.

• **Informal organizational structures and management systems give school-based mental health projects the autonomy and flexibility they need to meet a variety of needs in an often chaotic environment.** At the same time, some formal management mechanisms—such as district-level school health liaisons, regular staff supervision meetings, and periodic reporting requirements—support accountability and provide a means for resolving problems.

Implementation Issues

• **Although the objectives of schools, mental health clinics, community health centers, and health and school staffs are the same—to improve the well-being of all children, their goals differ.** The differences between goals lead to disparate roles for various stakeholders, which in turn can cause misunderstandings or implementation barriers. While mental health counselors try to delve beneath the surface of students' problems, stirring up troubling emotions so that students can address them and move on, schools have an interest in maintaining a calm, controlled environment that supports academic learning; in this setting, intense emotional upheaval is disruptive. School-based security officers focus on discipline, while mental health providers emphasize therapy, conflict resolution, and preventive approaches. Health center staff often focus on administrative or coordina-

tion responsibilities, while front-line mental health practitioners and teachers are consumed by students' immediate needs.

• **Schools with mental health services need clear policies to address differences in philosophy and methods between education, mental health, and medical health providers—especially regarding confidentiality issues and students' mental health-related grievances against school personnel.** Without clear policies, students can get caught in conflicts between health and school staff—an experience that can aggravate a student's problems and hinder therapy—and practitioners may become confused or resentful. Policies are especially important when multiple stakeholders are involved because front-line counselors and other practitioners are answerable to multiple authorities. At a minimum, the policies should clarify: Who determines the providers' goals and agenda? Who supervises the mental health/violence prevention staff? Who reports to whom? Whose procedures take precedence? Who evaluates services and student progress? What are the procedures for resolving problems?

• **The coordination of mental health/violence prevention efforts with school systems and education efforts benefits from solid backing from educators at all levels (school district administrators, principals, and teachers); the delineation of separate roles and responsibilities for school and mental health staff; frequent communication among stakeholders (both formal and informal); and out reach efforts that bring mental health staff in contact with students, faculty, and the community.**

• **Although mental health staff view violence prevention services and crisis intervention as equally important, preventive services seem to be harder to implement.** Responding to the chaotic and spontaneous nature of students' immediate problems often consumes all of the time and staff available, leaving virtually none for violence prevention.

• **Although many stakeholders should be involved in planning, a violence-prevention project needs a strong leader in order to evolve through the implementation stage.** The leader should have adequate time to contribute and be able to facilitate coordination between school and health staff and administrators, supervise mental health staff on-site, and spearhead outreach efforts.

• **Individuals who control funding and priorities for schools and health clinics must view violence prevention and conflict resolution as essential school-based services if implementation is to succeed.** If violence prevention/mental health services are not a priority, they are unlikely to receive adequate staffing, teacher time, and space because they must compete against too many other important components of school life.

Issues Involving Long-term Sustainability

• **Mental health services and staffing are extremely vulnerable to funding cuts and reimbursement obstacles.** State restrictions on billing for mental health services, Medicaid managed care, and the lack of sources for stable, sufficient funding all threaten the long-term prospects of the sites we studied.

• **Although project leaders struggle to identify quantitative measures of success, to move from process-based to outcomes-based evaluation, and in some cases to implement any evaluation at all, every site in our sample reported some evidence of success in meeting the needs of students through the school-based mental health/violence prevention project.** School, health, and mental health staff recognize: improvements in students' behavior and attendance, faculty attitudes, and the general school atmosphere; reductions in crises on campus; increased student requests for mental health services and reduced waiting time for services; and dramatic anecdotal evidence of success.

Program Background

In schools, we're pushing kids academically but we're just not developing them socially. Schools produce graduates, not adults. What's sad is we're not winning this war.

–School counselor

Violence is a true health issue that should be addressed as if it were a disease. [Conflict resolution] should be viewed as a crucial part of the school environment.... Let kids know that feelings are important and must be shared in a positive way.

–School-based mental health provider

Since 1993, the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA BPHC) has awarded special grants to three community health centers to improve and increase violence prevention and mental health services through school-based health clinics. The grants, administered by the Division of Programs for Special Populations, are part of the HRSA BPHC's overall strategies of addressing violence and related issues that affect health and expanding the mental health care component of school-based services.

The HRSA BPHC selected grant sites that demonstrated diversity in client demographics, degree of urbanicity, geographic location, and number of students served; practically the only feature each site had in common was an established school-based health clinic and an intense need for mental health care, crisis intervention, and violence prevention. Each site developed its own package of mental health/violence prevention services to meet the needs of its clients and community and address specific, local issues related to violence. Each site received identical funding: $100,000 in fiscal year 1993, $25,000 in FY94, and $25,000 in FY95. The sites included:

- **E.A. Hawse Health Center in rural Baker, West Virginia,** which operates a school-based clinic serving 750 students at East Hardy Early/Middle School and East Hardy High School.[1] Ninety-nine percent of the students are Anglo; drug and alcohol abuse are prevalent among students and their families. This project hired a full-time mental health counselor to provide long-term, in-depth counseling and crisis intervention to middle- and high-school students suffering from substance abuse and domestic violence. Counseling for elementary-school students focuses on healthy behaviors and crisis prevention. A 24-hour crisis hotline provides emergency referrals.

- **Baltimore Medical System, Inc., in Baltimore, Maryland,** which operates a school-based clinic at Thurgood Marshall Middle School. Ninety-two percent of the students are African American; 85 percent live in homes where substance abuse is present. In 1991-92, the school (then known as Herring Run Middle School) recorded 2,000 disciplinary incidents, including 347 attacks on students and 12 weapons violations; in 1993, the school had the highest arrest rate in the city. This project combined a classroom-based violence prevention curriculum, peer mediation training for faculty and students, group counseling in anger management and

[1] In November 1995. E.A. Hawse Health Center opened a second school-based health clinic at an elementary school in Moorefield, West Virginia.

self-esteem, and individual counseling to lay a foundation for developing students' conflict resolution skills.

• **Northeast Valley Health Corporation in San Fernando, California,** which operates a clinic at San Fernando High School. Ninety-seven percent of the students in this urban school are Latino; some belong to gangs, and many are recent immigrants who have acculturation problems. This project increased counseling services, reduced waiting time for mental health care, and improved case management and tracking. In 1994-95, the school-based clinic recorded more than 3,300 mental health encounters—55 percent of all health clinic visits.

This report and the attached case studies present insights based on each site's understanding of the issues, strategies, obstacles, and solutions involved in providing school-based mental health/violence prevention services. This is not an evaluation of the achievements and failures of the projects; rather, it is a compilation of lessons learned that will be useful to a diverse audience, from front-line practitioners to policy makers to funders. Because our sample included only three sites, which were chosen for this study because they had attempted violence-prevention efforts (not because they had necessarily succeeded in implementing their plans), we cannot generalize these sites' observations to all communities. However, we found remarkable consistency across sites in our sources' description of the issues and challenges they face.

The information in the report is based on telephone interviews with many sources: health and mental health care providers and administrators; teachers; principals; school counselors, nurses, and psychologists; school district representatives; parents; students; community members; and law enforcement officials. We also visited each site to observe the projects in action and to conduct in depth interviews.

We have organized this report around major topics rather than stages of project development because the issues our sites identified as most important cut across the chronological phases of planning, design, and implementation. The first section addresses key services and features of school-based violence prevention projects; the second section addresses program administration; and the third section deals with financing, accountability, and evidence of success. A final section presents a "wish list" of ingredients of violence prevention projects suggested by practitioners. Throughout the text, we have included boxes of examples from real-life cases (using fictitious names) that illustrate our findings. We have also included "Tips from the Field"—practical advice our sources offer directly to their peers and to decision makers in other communities. The case studies in the appendix contain details pertinent to specific sites as well as an explanation of how project planning evolved.

Key Features of School-based Mental Health/Violence Prevention Projects

Important features include school and community context, services and activities that support violence prevention or mental health, referral systems, parental consent for services, confidentiality rules, and adequate space and appropriate locations for services.

The Role of Community and School Context

Although they are located in vastly different communities, each of the sites in our sample serves students who are frequently exposed to violent or disruptive circumstances in school, at home, or in their neighborhoods. In rural West Virginia, students suffer the effects of poverty, high divorce and remarriage rates, alcoholism and drug use in the home, domestic violence, or absentee parents who work long hours at jobs far away from home. Many students in Los Angeles' San Fernando High School live in fear of gang-related violence on the streets and abuse at home; recent immigration raises problems associated with acculturation. High rates of gang-related and neighborhood violence plague the students of Thurgood Marshall Middle School in industrial Baltimore, many of whom also feel the burden of their families' unemployment, alcohol and drug use, and abusive behaviors.

Although students' circumstances vary across sites, they yield similar potentially disastrous effects. At all sites, schools and communities are chaotic and desperate. Students' psychological and behavioral responses to the dangers they face include:

- Depression
- Low self-esteem
- Post-Traumatic Stress Disorder
- Gang membership
- Disruptive and violent behavior
- Suicide ideation
- Drug and alcohol abuse
- Unsafe sexual activity
- Dropping out of school

Inhibited access to community mental health services add to the need for school-based counseling at two sites. In East Hardy County, the nearest mental health provider other than the health center is more than 40 miles away, and parents have difficulty getting time off work to transport their children to appointments. In contrast, although several community mental health services exist in San Fernando cultural resistance is high: Latino families put a high value on privacy and stigmatize mental health problems. For all three sites, school-based mental health care may be the only realistic source of help for students whose difficulties stem from serious problems at home; program staff say that families with unhealthy behaviors rarely seek mental health support for their children.

The planners of these school-based violence prevention projects recognized local needs and circumstances and designed and adapted their services accordingly. Some projects benefit from local circumstances—for example, San Fernando expanded its services by hiring mental health interns from nearby universities. Contextual factors may also limit or restrict services. At one site, a conservative community prevents school-based mental health staff from discussing sexuality or sexual issues with students; at another site, the school's reorganization into sub-schools divided by locked doors complicates service

implementation. Local context also can create needs for more services or different types of services. For example, the earthquake that hit San Fernando in 1994 dramatically increased the need for mental health services by shaking up other issues for students and their families. In West Virginia, planners incorporated a 24-hour crisis hotline into the project as a way to reach a dispersed and isolated population.

Activities and Services That Support Violence Prevention and Mental Health

The ideal configuration of services varies for different sites. Planners at the sites we visited structured activities and services according to the school setting, available resources, and students' needs and circumstances. Many of the services considered important by health staff are not explicitly violence-oriented; rather, they address students' self-esteem, decision making, and ability to manage interpersonal relationships and impart skills in responding to or avoiding violence. Mental health counseling that gives victims of violence a supportive emotional outlet is also a key feature.

The array of activities and services across the three sites included:

- Mental health counseling in group and/or individual sessions
- A 24-hour crisis hotline
- Classroom instruction in a violence prevention curriculum
- A peer mediation program that trains students in conflict resolution and teachers in facilitation
- Classroom support for school health/ wellness programming
- Participation in student disciplinary proceedings

These services are designed to respond to site-specific needs. Although mental health counseling forms the primary violence-prevention strategy at two sites, for example, counseling practices are different. At San Fernando High School the student population is large and anonymous enough—and the adolescent students are mature enough—that most students can receive group counseling. The groups address very specific issues such as acculturation or sexuality, and some are offered in Spanish. But in East Hardy County, the population is so small that students are reluctant to open up to one another in groups; here, the mental health counselor conducts only individual sessions.

Even within a type of activity, services vary according to local needs. For example, during a recent week a mental health provider at one site tackled a range of counseling cases (see box page 5).

Selection of Services

Planners' objectives and goals, in addition to local context, influenced the selection of activities and services at the sites we visited. At Thurgood Marshall, for example, planners hoped to reduce fighting and reverse the escalation of minor incidents by promoting conflict resolution. Thus mental health counseling is accompanied by a peer mediation program that trains students in conflict resolution and by classroom instruction in a violence-prevention curriculum. In choosing these activities, the program manager deliberately sought violence-prevention services that would (1) ultimately lead to school ownership, (2) be inexpensive to sustain, (3) be self-perpetuating, and (4) relate to instructional or educational strategies such as cooperative learning. Implementers have found that no component alone is sufficient to reach the students who need help. As the facilitator who implements the classroom curriculum observed, "Peer mediation is like teaching 20 kids to read and then having them teach the rest of the school to read."

Even When Violence Prevention Is Limited to Counseling, Mental Health Providers Vary Services to Meet Diverse Needs

• A second-grade student was referred for counseling after swearing at the principal and school bus driver, pulling down her underwear, and other inappropriate or violent acts. The counselor knew that the girl had been sexually abused and had worked on that problem with the girl and her mother. After learning that the mother is seeking a divorce to escape domestic violence, the counselor set up an Individual Education Plan for the student and scheduled after-school and evening counseling sessions for mother and daughter through the divorce period.

• A middle-school student refused to do his homework or work with his teacher. The counselor knew the student had an alcoholic step-father; while talking with the mother he learned the parents are getting divorced. The counselor and mother worked together to convince the student that taking his anger out at school only hurts him.

• A 10-year-old boy in third grade is prone to violent and abusive behavior. The counselor set up a behavior management plan to reinforce positive behavior and discourage negative acts.

• A high-school student was suspended for verbally abusing a teacher. He has an alcoholic father and is himself a substance abuser. The counselor collected the student's homework from teachers and called him to reinforce the importance of completing his work so he doesn't fail the grade—again.

• After three counseling sessions for depression, a 13 year-old girl confided that she had an abortion at age 11. The counselor set up a schedule for long-term individual counseling.

Although mental health staff view violence-prevention services as equally important as crisis intervention (if not more so in the long run), preventive services seem to be difficult to incorporate because the chaotic and spontaneous nature of students' immediate problems consumes almost all of the time and staff available. One mental health provider told us that he spends less than 15 percent of his time on preventive efforts. With the exception of the ambitious three-pronged strategy in Baltimore, these projects seem to start with crisis prevention and then try to add violence prevention over time. In addition, counseling can serve indirectly as a violence-prevention strategy for students who must cope with potentially explosive or harmful situations. A child who learns to confront problems with emotional maturity gained through counseling can avoid violent situations or find alternative ways to express anger or frustration (see box below).

Counseling Services Can Address Violence Indirectly but Effectively by Giving Students Coping Skills

At home, the four "Baker" brothers were terrorized by an alcoholic, abusive father. At school, the boys (aged 5 to 12) fought constantly with other children, who called them "Swamp Feet" to mock their poor hygiene.

The school-based mental health counselor met with the brothers individually and as a group with their parents. His first questions were simple: Did they have washing facilities at home? Were their clothes being washed regularly? How often did they bathe? Then the counselor suggested new ways the boys could interact with other children without feeling picked on and without picking fights. After the counseling sessions, the Bakers' hygiene and behavior improved immediately—and the fighting diminished. Now, the boys visit the principal's office only once or twice a week, instead of two or three times a day

Patterns in Service Use

Increases in mental health staff and the availability of counseling led to increased demand for services at several sites. The more that students feel services are accessible and immediate, the more likely they are to seek help, counselors said. Also, as projects gain acceptance in the schools, students may make repeated visits or encourage their peers to use the services. Every site reported a steady (or even dramatic) increase in service use since the violence prevention project's inception.

Although every site reported seeing an array of student problems, some staff noted clear patterns of service use. For instance, 70 percent of the students receiving counseling at San Fernando are female, a majority of whom are Latinas seeking help for low esteem and acculturation problems. Counselors here have found that self-esteem issues are often the result of abusive

relationships. Male students at San Fernando—particularly those who are Latino—tend to avoid counseling because of the cultural stigma attached to psychological or emotional intervention. The exception to this pattern is homosexual students, both male and female, who use mental health services frequently and view the mental health clinic as a safe place on campus.

Other patterns in service use are age-related. In East Hardy County, where the mental health counselor serves children in kindergarten through twelfth grade, younger children respond better to short-term counseling sessions that teach coping skills while adolescents benefit from longer, more therapeutic treatment for complex problems.

Designing and Coordinating Referral Systems

Because violence-prevention projects rely on teachers, administrators, and other school and health staff to refer students, project staff recognize the need for a referral system. At most sites we visited, teachers refer students to counseling by contacting a counselor personally; some sites also provide teachers with referral forms. Several teachers said they refer students to counseling because it takes a burden off them. "In the past, I would have talked to the student myself," said one teacher, "but I'm always afraid I'll say the wrong thing." All sites said that most referrals come from a small core of extremely supportive teachers and that some teachers never make referrals.

At some sites, school administrators refer students to counseling as part of the disciplinary process. Providers at other sites indicated that they would like to be viewed more as part of the disciplinary process because it would increase referrals. At Marshall Middle School, the only site in our sample where peer mediation was part of the special violence-prevention grant, students are referred by teachers or other students to peer mediation in the hope of defusing potential conflicts before punishment is necessary.

School counselors, psychologists, and nurses also refer students to the mental health/violence prevention projects. School counselors at all sites were unequivocally pleased that mental health staff are available to provide long-term, in-depth, or therapeutic psychological counseling. The school staff either inform mental health providers of student needs or bring students directly to the mental health offices. School nurses are an important source of mental health care referrals because students' complaints of physical ailments often indicate deeper emotional or psychological difficulties.

Medical providers at all of the school-based clinics in our sample also identify students who may need mental health treatment in addition to—or in place of—medical care. All three sites ask students seeking health services basic questions about their emotional state, high-risk behaviors, family life, and experience with violence. Health staff evaluate students' responses for indications of suicidal thoughts, sexual or physical abuse, sexuality issues, or drug or alcohol use. Students whose responses indicate problems are referred to mental health staff.

Students with Difficult Mental Health Needs May Respond Best to Indirect Referrals

A school psychologist who regularly refers cases to the school-based clinic's mental health counselors recalled the case of "Mike," a 17-year-old cocaine addict who attended a nearby alternative school. Although blackouts had destroyed Mike's sense of time and he was afflicted with nosebleeds and ulcers, he resisted counseling. "Getting him to look at his addiction was too threatening," recalled the psychologist, "but I got him into the clinic to treat his ulcer. Once he realized the clinic was a safe place, he got into a counseling program." Now, Mike is in the regular school full time and plays an active role in parenting his two-year-old child.

Practitioners may negotiate multiple referral systems to ensure the best method of counseling and to prevent children from falling through the cracks. For example, when a 17-year-old student at San Fernando High School indicated suicidal thoughts in his journal writings, his teacher photocopied the writings and shared them with the school nurse, who passed them along to the school-based clinic's mental health coordinator. The teacher also referred the student to IMPACT, a federally funded program at the school that trains teachers to help students address substance abuse and grief issues. When the IMPACT coordinator met with the student, she verified that he had parental consent for school-based clinic services and then called in the mental health coordinator to arrange long-term counseling. (Although IMPACT teachers have some training in counseling, they refer cases that require in-depth treatment to the school-based clinic's mental health staff.)

A School Counselor and Mental Health Provider Coordinate Referrals to Address Students' Privacy Concerns

A high school freshman told her school counselor she was worried about her friend "Jane's" sexual activity, suicidal thoughts, and plummeting grades. The school counselor met with Jane and found her receptive to counseling but reluctant to open up to him because she would have to see him in the halls every day throughout her school career. The school counselor referred Jane to the school-based clinic's mental health counselor, who met with her regularly for several months. Jane's attitude improved along with her academic performance. She began to think positively about her future and signed up to take the PSAT test in preparation for college.

At all three sites, project staff actively encourage and coordinate referrals from school staff. Some sites use a proactive approach; for example, mental health providers at San Fernando High School periodically invite faculty to brunches to show their appreciation for teacher referrals. Teachers also receive a thank you note after referring a student to mental health services. At another site, a counselor hand-delivered referral forms to teachers and conducted follow-up conversations with teachers who did not respond. Other counselors make sure they are accessible to teachers and other school staff by spending time in hallways, faculty lounges, or front offices. In East Hardy County, the counselor attended faculty meetings, met personally with every teacher upon his arrival at the schools, and talks with principals every day. (Other issues surrounding cultivating support from teachers are discussed later in this report.)

Referrals from Teachers Increase as Teachers See Improvements in Classroom Behavior and Student Well-being

At 15, "Maria" was a tough-looking and hard-acting tenth-grader who liked to fight and sported a haircut favored by female gang members. But her responses on a questionnaire distributed by her magnet school's coordinator indicated that Maria had suicidal thoughts and had tried to kill herself twice—once with a knife and once by overdosing on cocaine.

"She looked like she could beat up the world," said the magnet teacher, "but underneath was a very sad little girl who had been sexually abused by her father with her mother's knowledge." The teacher called the school's intervention program and the school-based clinic, who conducted a formal assessment and set up individual counseling sessions.

After Maria began counseling, her teacher noticed small improvements every day. Maria wore less makeup, she abandoned her harsh haircut, and her clothing became softer. Over a three-year period, her schoolwork improved and she eventually graduated. Today, Maria is a scholarship student at a competitive college—studying social services. And the teacher who connected Maria with the counseling project has become a frequent source of referrals for the mental health providers.

Obtaining Parental Consent for Services

Health clinic practices (and, in one case, state law) require parental consent for mental health services at all sites. Each site uses a blanket consent form for school-based services that permits both medical and mental health care. Two of the sites allow parents to exclude some services from their consent, including mental health care, but relatively few parents have

excluded counseling or mental health services. In West Virginia, where parents must contact the school-based mental health counselor if they do not want their children to receive services, two families have prohibited counseling for religious reasons. In California, where parents identify excluded services in a special box on the consent form, some parents have actually excluded some medical services but allowed counseling. At all sites, a signed form is valid for the duration of a student's enrollment in school.[2]

Obtaining consent requires some effort. The school-based clinics are usually responsible for distributing the forms, through a mass mailing at the beginning of each school year and by sending forms home with "unconsented" students who seek health services during the school year. Although the consent rate was as high as 90 percent at one site, health clinic administrators at most schools said they struggle with the logistics of obtaining parents' permission. Because parents of at-risk, high-need students often are transient or distracted by other problems, parental consent is difficult to obtain through the mail or by sending forms home with students. Some health care providers view the school nurse as the most effective means of obtaining consent for mental health services because she or he usually sees all new students and their parents when they register for school.

Several sources said that the lack of a single individual with responsibility for collecting consent forms, especially in a large school, makes the process of obtaining consent complicated. At San Fernando, for example, consent forms are (1) distributed by the health clinic; (2) distributed by the mental health clinic; (3) included in registration packets given by the school to new students; and (4) distributed by the school nurse, who sees all new students during registration. Several sources said the process would go more smoothly if one person was in charge of obtaining consent.

Conflicting consent policies can pose obstacles. In California, state law allows children above age 12 to seek counseling for family planning without parental consent—but the school district requires consent for all services. San Fernando's school-based clinic follows the school's rules and requires mental health staff to obtain consent for all counseling, but by requiring this consent the clinic becomes ineligible for certain state funds.

Confidentiality Rules, Obstacles, and Solutions

Mental health providers work under strict confidentiality protocols because of the sensitive nature of mental health problems. Although this practice reassures students who are uneasy about discussing their problems with counselors, in a school setting it can cause several problems:

- Teachers, principals, school nurses, and school counselors are accustomed to talking with each other about students in order to piece together an understanding of their strengths and weaknesses. When mental health counselors decline to join in these discussions, educators may feel slighted or frustrated in their attempts to generate professional collaboration. Resentment can create barriers between the very people who need to coordinate their efforts to best serve students.

- Parents and students can get caught in confidentiality conflicts between school districts and mental health professionals. For example, San Fernando High School has a policy that parents must be notified if a student has attempted suicide. But mental health staff believe that this policy may not be the best practice because the parent may be part of the student's problem, and the student may not receive the

[2]At Thurgood Marshall Middle School the form expires after three years, but a student who progresses with the rest of his or her class would graduate within this period.

intervention he or she needs if the parent is notified. Mental health staff operate under a different protocol: They do not notify a parent unless there is immediate danger to the student.

- Confidentiality rules protect students' privacy but can delay access to services if the providers who control health information are not available. This is primarily an issue at sites where mental health providers are not on campus all day and school staff may not have all the information they need to intervene in a crisis.

- If a project supplements its staff by using mental health interns, as San Fernando does, staff supervisors must establish rules for sharing information that allow the interns to gain advice on treating specific cases while still maintaining student privacy.

All three sites uphold strict confidentiality policies but have developed ways to communicate without violating student privacy. At two sites, school counselors and nurses use coded language to discuss cases with the mental health providers. At one site, a school staff member who has knowledge about a student's history of abuse may refer the student to the mental health counselor by saying, "This is a 'confidential' case and I've taken care of it"—meaning, "This case involves sexual abuse and I have filed a report with the authorities." The mental health provider understands the comment to mean that he or she should provide appropriate counseling. At another site, the mental health coordinator will not answer direct questions about a student's problems but may say, "I can't verify that, it's 'confidential.'" The implicit meaning is that the questioner has guessed correctly. Health providers do not use these strategies if the questioner is merely curious; they are reserved for cases in which school and health staff must coordinate their efforts to provide comprehensive care.

In some cases, mental health projects must overcome logistical challenges to confidentiality. Early in San Fernando's project, providers had to shuttle patients' mental health records back and forth every day between the school-based clinic and the mental health bungalow, located across campus. Program staff worried that charts could be misplaced or read by students or unauthorized adults. Now, all medical records remain inside the health clinic; counselors maintain case notes on separate clinic note sheets that they periodically take to the health center to update the files.

Despite these strategies, some confidentiality issues remain unsolved at the sites we visited. At San Fernando, some students who use the mental health services reported feeling uncomfortable with the method for releasing students from class for counseling appointments. In order to leave class, students must present the teacher with a bright orange card that contains the student's counseling schedule and space for the teacher's signature. Because these cards are so noticeable and obviously identified with the clinic, some students are embarrassed to display them.

Securing Adequate Space and an Appropriate Location for Services

At all sites in our sample, the schools were responsible for contributing space for mental health services. (As one principal noted, "If someone offers you a service or gives you personnel, you find the space.") Local resources and circumstances play a significant role in determining the location of mental health services, however; schools often lack the facilities or funding to provide enough space to meet the demand for services or to provide adequate privacy. Mental health facilities at the sites we visited ranged from a cramped bungalow housing half a dozen providers on the fringes of the campus, to a converted storage closet that—although small—was private and furnished with

comfortable new furniture, to a modest but multi-room clinic supplemented by two tiny "peer mediation rooms."

The type of space and the location that a mental health/violence prevention project requires varies according to the services that it provides:

- Individual counseling requires access to places where the counselor and client can talk without being overheard.

- Group sessions and peer mediation require enough space to accommodate several students and a location where loud conversations won't disrupt other activities.

- Implementation of a classroom-based violence prevention needs no meeting space—only some office space for the facilitator who conducts the sessions.

All types of projects require office space for mental health providers to store student records and, ideally, meet with students on a consistent basis. Without some sort of headquarters, mental health and violence prevention efforts are left to grab whatever classrooms are available at a given time. The lack of predictability makes it hard to schedule long-term counseling and is disruptive to students who already face turbulent lives.

Ambiance and location are important features because mental health and violence prevention services ask children to take emotional risks and confront painful experiences; this is much easier done in an inviting atmosphere. In San Fernando, the mental health bungalow sports colorful student art, stuffed animals, and threadbare but comfortable couches—unusual by school standards but very attractive to students. The bungalow's distance from the main school buildings reduces any criticisms the unconventional-looking office might receive if it was more visible to school staff, and the proximity of school-mandated mental health staff and the mental health clinic's providers in the same bungalow encourages communication, interaction, and coordination.

Health providers, school staff, and students at the sites we visited identified both pros and cons with most space arrangements. Some sources said the physical separation of the mental health clinic and the school-based health clinic at San Fernando High School impedes informal communication among health providers and would make supervision by the health clinic director more difficult if it were needed. The mental health clinic's cramped quarters make services more chaotic and demonstrate a low priority for mental health care, according to some staff; it also limits privacy. Rooms are not always available for counseling, the location of group sessions tends to shift, and staff must leave a radio playing loudly to block out private conversations. On the other hand, students say the mental health clinic's distance from the main school buildings affords them more privacy when they decide to seek services—and although placing multiple services in a single bungalow limits office space, it also removes the stigma associated with an office that only treats mental health needs. The fact that the school district provided the counseling service with its own bungalow may, in fact, indicate that counseling is a priority for the school.

Some school structures, while supportive of education, do not encourage collaborative mental health efforts. At Thurgood Marshall Middle School in Baltimore, where a large student population is divided by locked doors into smaller sub-schools with separate halls and classrooms, school staff and administrators rarely interact. Although the two schools' teacher-coordinators trained together for peer mediation, there is no coordination among mediators at the separate schools, and one sub-school has had a much harder time implementing the program.

Program Administration: Key Roles, Responsibilities, and Relationships

Administration topics include management and organization structures; staffing configuration, roles, and issues; integration and coordination between mental health and education providers, systems, and institutions; parent, family, and community involvement; and cultural responsiveness.

Management and Organization Structures

At each site we visited, the community health center that operates the school-based clinic has designated a key administrator with oversight of the school-based health and mental health services. In San Fernando and Baltimore, these administrators are located on campus at the health clinic. At all sites, these administrators rely on an on-site lead counselor or health clinic staff member who has direct oversight of the mental health staff and services. (In East Hardy, the mental health counselor is the sole staff member of the project.) The project leaders report regularly but informally to supervisors at the school-based clinics and community health centers. In some cases, the health center or clinic administrators also have some accountability to the school district.

A project leader's roles and responsibilities may include:

- Counseling
- Scheduling counseling sessions
- Assigning cases to staff members
- Supervising staff members
- Communicating with school administrators and staff
- Attending school meetings
- Coordinating efforts with other school health providers and outside agencies
- Making classroom presentations
- Adapting program design to meet students' needs (e.g., creating new group sessions to address specific topics)
- Leading crisis intervention
- Resolving misunderstandings between school and mental health staff
- Collecting and maintaining data on services and recipients
- Reporting to health clinic supervisors and/or administrators at the community health center

The organizational structures and management systems for these projects are largely informal. Top administrators trust their front-line practitioners to have the best understanding of what is needed, and funding and staffing are usually too limited to allow micro-management. Informal management encourages front-line health providers to be autonomous from both the school-based clinic and the community health center. In turn, autonomy and flexible management help prevent burnout of mental health staff. "I give people a lot of latitude," explained the director of a project that has low staff turnover

despite a high-pressure work environment. "If [management] is too structured, you're focusing on the institution rather than on what you're trying to accomplish." Agreed another mental health provider, "Once you get real structured, you get rigid.... You have to be able to respond, to meet [spontaneously] with people."

Informal but frequent supervision and communication among counselors, school-based clinic staff, educators and school administrators, and community health center administrators are well suited to the flexible scheduling needs of school-based mental health practitioners. Most sources said they preferred informal arrangements for staff supervision, information sharing, and networking; between the hectic nature of the school day and the unexpected crises that mental health providers must address, it's difficult to find the same block of time each day or week for formal meetings. Informal networking also builds individual relationships among caregivers and focuses on specific needs, problems, or issues rather than "talk for the sake of talking," sources said.

Some formal management mechanisms are also useful. Periodic reports from the mental health staff to the community health center and principal, and from the health center to the school district, support accountability and provide input for program planners. Similarly, the existence of a liaison for school health within the school district administration can support school-level staff and help resolve issues for both school and health practitioners. In San Fernando, the school district's coordinator of school-based health clinics helps raise funds, obtain facilities, handle bureaucratic matters such as bidding and code regulations, compile assessment data, represent the interests of school-based mental health care at school board meetings, and mediate coordination problems between school and health staff. On-site staff do not have the time or detachment to perform these tasks. Mental health administrators also view the district liaison as an important advocate: "He's the one who will get up and make an emotional speech at a national conference," one said.

Supervision Helps Staff Devise the Most Effective Treatment for Students with Complicated Mental Health Needs

Seventeen-year-old "Carmen" first visited her school's mental health clinic with a friend who had been raped. But counselors soon learned that Carmen needed help with her own problems; she had been abused at a day-care center when she was six years old and had trouble getting along with her family. As therapy progressed, counselors uncovered a surprise: The woman Carmen thought was her mother was actually her half-sister—making her alleged father her actual brother-in-law and her alleged sister her actual niece. Carmen's sister/mother had promised their dying father that she would raise Carmen as her own child, and she had—without telling Carmen.

After family members admitted these facts to the counselors, they arranged a meeting at which Carmen was informed. Later, as Carmen worked through her anger, she began to make up fantastic stories in an attempt to manipulate her therapist, a mental health intern who already felt challenged by the complicated case. The intern would base her approach on Carmen's false statements, only to learn after weeks of therapy that she had been misled.

The therapist sought advice on the case with the mental health coordinator during weekly supervision meetings. The guidance she received enabled the mental health intern to confront her own feelings of frustration and to insist that Carmen approach therapy more productively.

Whether formal or informal, sources agreed that supervision and oversight mechanisms should be established and explained to school staff when a mental health project is implemented to avoid confusion. It is especially important to define who conducts oversight and supervision. Is it the responsibility of the principal? The guidance counselor or other school mental health staff, who often don't have time? Or the health center? Will the violence prevention counselors follow the same goal-setting and assessment procedures that govern the school's mental health experts? These decisions send important messages to school staff about the

expectations, goals, and accountability of the mental health component. Without clear mechanisms, school staff who are dissatisfied with the counseling program are likely to take their concerns to school counselors or nurses—people they know well but who have no control over the program and little time for this extra burden.

Staffing Configurations, Roles, and Issues

The school-based violence-prevention projects in our sample established different staffing configurations based on the services they offer, the size of the population they serve, and the resources available. There is no prescription for staff configurations or size—although all sites recognized a need for more counselors to meet the growing demand for services. Staff size across sites ranged from one to 11 full- or part-time members. Each project included one health clinic employee who provides administrative oversight.

Mental health staff must make many adjustments to working in a school setting. Unlike private practice, where individual clients receive regularly scheduled, hourly appointments, the demands of the school setting require a flexible, accommodating approach that coordinates school and health needs. In contrast to private practitioners, school-based mental health professionals cannot spend patient contact time conducting lengthy evaluations—they have to jump into counseling quickly. School-based mental health staff may also face conflicting demands from their supervisors, school administrators, or other school staff. In addition, students cannot miss the same class every week, so counseling schedules must rotate across class periods and appointment times must match class periods. Further, the hectic schedules of both students and staff mean that patients may not always see the same counselor each time—so mental health staff cannot be possessive about their clients.

Effects of Staff Background, Qualifications, and Training on Program Quality

Staff backgrounds varied considerably across sites, but prior experience working with troubled young people and in schools seems to be valuable preparation for working in a school-based violence prevention project. This experience gives mental health staff credibility among educators; familiarity with young people's needs; and an understanding of the demands faced by teachers and administrators, the bureaucratic chain of command in school systems, and the functions of special student programs and support services.

Whatever their level of experience, all new staff need time to adjust to the school environment and to establish trust and rapport with students, parents, and school staff. It takes some time for any new program to build a foundation in schools. In a counseling situation, this transition time is especially important because students will not open up to a complete stranger. Parents, teachers, guidance counselors, and other staff may not understand or feel comfortable with the mental health practitioner's role until everyone has had time to adjust. The amount of orientation time depends on the people involved, but some sources said it takes about a year.

Limited resources, stressful conditions, and rural or unsafe environments can make it hard for school-based mental health/violence prevention programs to attract and keep appropriate staff. School-based programs can't offer the office space, support staff, income, regular schedules, attractive environment, and other benefits of private mental health practices. Opportunities for clinical supervision and peer consultation are often more limited in school settings, which can isolate mental health care providers and contribute to staff burnout. Appropriate mental health staff may be hard to find in (or attract to) rural, isolated settings. And some staff find the constraints of working in a

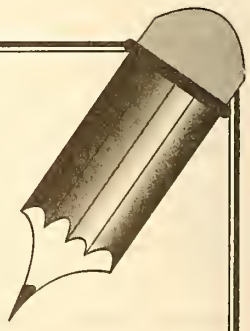
school (e.g., adjusting counseling schedules to reduce missed classes) frustrating and distracting in the face of students' acute mental health needs. "It's like two separate worlds," said one counselor, comparing the provision of mental health services in schools and in traditional settings.

Although using interns expands the counseling staff and increases students' access to services, blending multiple skill levels and therapy styles requires close supervision. Interns offer a cost-effective way to provide counseling to more students, and over time their commitment to a project increases staff continuity. They also benefit from the experience they receive—and might be motivated to work in school-based settings in their professional careers. However, interns can bring an unpredictable mix of experiences, philosophies, and styles to the table. Supervisors must blend these styles and skill levels and make sure they match students' needs.

Mental health and violence prevention projects are vulnerable to changes in staffing. Staff turnover can jar the young people who trust and confide in counselors or other staff. A project may lose momentum or the confidence of the school community if a staff member leaves, particularly if he or she played a key role in operating the project. For example, a teacher who served as her sub-school's peer mediation coordinator at Thurgood Marshall Middle School left the school a year after the project began. Since her departure, the peer mediation program in her sub-school has temporarily disappeared. Sources at other sites agreed that even small staffing changes can have serious repercussions—both positive and negative—on projects. After an outside peer mediation trainer was rejected by teachers at one site, and the program faltered, staff obtained a new trainer who is loved by the school and who injected new life and enthusiasm into the project.

A school-based mental health care provider who is employed by a community health center, rather than by a school district, can facilitate the health center's connection with schools and parents. Providing the mental health professional gives the community center an essential role in the collaboration with the school and enables the center to provide a service that the school needs but may not be able to afford. "By [the lead counselor] being one of our staff people, it makes the linkage between us and the school much stronger and much more coordinated," a health administrator explained. "Any service we can provide to the school, they look at it as us being cooperative." In addition, a school-based mental health counselor who is also a health center employee may have an office at the health center where he or she can see parents who are intimidated by schools or can only make evening appointments (when school buildings are usually closed).

Tips from the Field:
Blending Staff Styles

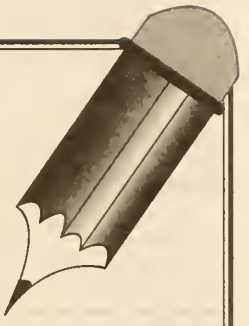


1. Respect and discuss divergent approaches. Assign and refer students among staff members to provide the best match of needs, personalities, and counseling styles.

2. Promote a relaxed atmosphere in the mental health clinic so individual styles can develop.

Having at least one school-based mental health provider on the health center's staff also facilitates referrals from the school-based clinic to the mental health project, because the various health providers tend to interact regularly in staff meetings and in the community health center offices. Because many referrals to mental health staff originate from students' visits to the health center for emotionally-related physical complaints, a cooperative effort between school-based medical and mental health staff is essential.

Tips from the Field:
Hiring and Keeping Appropriate Staff



1. Involve principals and/or other school staff in hiring decisions, to eliminate turf barriers.

2. Interview job candidates on campus so they realize what school-based services involve.

3. Make sure the job candidate has worked with children or adolescents. Staff with this background are less likely to be overwhelmed by students' problems and are better equipped to work with young clients who may have trouble articulating their problems.

4. Look for staff who are:

- Able to establish rapport and trust with students and teachers
- Patient, flexible, adaptable, and able to meet children and parents on their own terms
- Experienced with the school system, young clients, and drug or alcohol abuse
- Able to cultivate support among school staff
- Empathetic without being overly invested in students' problems
- Trained in crisis counseling but resistant to a reactive, crisis orientation

5. Don't be afraid to ask pointed questions to assess how a potential staff member will react to students' problems. Does the counselor have values concerning teen pregnancy or undocumented immigrant status that might be at odds with the reality faced by students?

6. If you don't have time to provide a full orientation for new staff members, at least match the new staff up with a veteran staff member whom he or she can turn to for advice.

7. Provide an outlet for frustrations to prevent burnout. Encourage counselors to discuss personal reactions to cases—especially situations in which a student makes the counselor angry or a decline in group session attendance makes the counselor feel insecure.

Integration and Coordination Between Mental Health and Education Providers, Systems, and Institutions

Ideally, mental health/violence prevention efforts are integrated into education efforts in some way that builds project credibility and school ownership of the program. When teachers bring mental health/violence prevention activities into their classrooms, through their own instructional practice or by welcoming project staff, more students receive exposure to the project's lessons and services.

Integrating Mental Health Care/Violence Prevention and Education Efforts

All sites in our sample use some type of faculty development to integrate mental health/violence prevention and education efforts. Teacher involvement in conflict resolution may increase the likelihood that more problems will be resolved in the classroom and will not need interventions such as peer mediation, according to a school counselor who suggested a minimum of one full day of faculty training. Faculty development also reduces the chance that teachers will counteract the project's conflict resolution strategies or give students mixed messages.

Violence-prevention efforts can also find a place in a school's educational program by sending practitioners into classrooms to deliver violence-prevention or mental health curricula and to provide information about school-based mental health services. Mental health providers at the sites we visited also participate in schoolwide health fairs or contribute mental health curriculum units to a health or personal development class.

Finally, mental health providers can be a resource for teachers seeking new ways to address behavioral problems in the classroom. A counselor at one site was able to coach a teacher through a difficult interaction with a fifth-grade girl who exhibited unusual behavior. With the counselor's one-on-one training, the teacher helped the student feel comfortable enough to talk about the problem and find a solution.

Efforts to integrate violence prevention/mental health programs into the educational work of schools meet with resistance at some sites, however. Curricula that are developed outside the school without the input of faculty, administrators, or district personnel can cause confusion or resentment among school staff. School administrators like to know what information is being taught to their students—especially if parents inquire—and need to be kept informed. Also, outside practitioners who enter the school to deliver training or guidance may not mesh with the school's culture, philosophy, or personalities. These difficulties are alleviated by good communication between school staff, project staff, and any outside providers before a new curriculum or program is introduced and throughout its implementation.

Integrating Mental Health Care/Violence Prevention and Schools

Mental health/violence prevention plays a role in schools beyond education, especially regarding discipline, school environment, education reform, and institutional goals.

School-based mental health services can play a role in disciplinary actions within a school or school district. At one site in our sample, the school-based mental health provider makes presentations or submits letters on student behavior to school board disciplinary hearings. Often, the school board will return an expelled student to school on the condition that he or she begins counseling with the violence prevention counselor. At another site, a counselor took a proactive role against a disciplinary action he deemed too severe (see box page 17).

Most mental health staff would like school administrators to view mental health services as a resource for disciplinary action because it

A Counselor Intervenes in a Disciplinary Measure on Behalf of Homosexual Students

The discipline of a gay student at an urban high school prompted the mental health clinic's coordinator to call for better treatment of homosexual students in a speech to the school district's board of directors.

"Freddie," a 16-year-old with oppositional disorder (a tendency to challenge everyone), was a frequent victim of anti-gay harassment in school. School administrators and teachers sometimes confused Freddie's homosexuality with his emotional disorder and accused him of flaunting his sexuality. On one occasion, a school security guard allegedly called Freddie a "faggot"; later, Freddie felt school administrators blamed him for provoking the incident. After many similar incidents, Freddie sought therapy, and his counselor watched the youth develop anger management skills and self-esteem. Freddie's grades and school attendance gradually began to improve. Nonetheless, school staff finally recommended placing Freddie in a private school for at-risk youth with behavior and emotional problems.

The mental health coordinator arranged to address the school board on Freddie's behalf. "The system failed [Freddie] and blamed him," the counselor told the education officials. "Freddie's problem... was caused by institutional intolerance and prejudice.... Freddie should be seen as a lightning rod who sheds some light on institutionalized homophobia, rather than a problem to be gotten rid of."

The counselor's presentation did not change Freddie's fate, but mental health providers at the school noticed that school administrators and some staff seemed more respectful of mental health services.

increases referrals of students in need of counseling. In East Hardy County, 90 percent of the students who are sent to the middle school principal's office for discipline are referred to the violence prevention counselor for counseling. At another site, however, most girls who get into trouble in class are sent to the school nurse, who is likely to refer them for counseling—but boys are usually sent to an administrator in charge of discipline, who is less likely to view counseling as part of the solution.

Violence prevention/mental health projects support schools' goals of improving the learning environment. Principals told us that mental health counseling and conflict resolution efforts improve the school environment by teaching students citizenship skills, providing tools for resolving crises, and enabling students to deal with emotional stress that can interfere with learning. Attendance also tends to improve when the level of violence in school declines and students (and teachers) feel safer.

Some educators view certain conflict resolution activities as complementary to education reform. A principal, teacher, and school counselor each said that the peer mediation skills taught at their school fit with the cooperative learning techniques they are adding to classroom instruction. Both approaches teach students to work together and to jointly develop problem-solving skills. Similarly, a health program director said she took a cue from education theory when she deliberately selected a variety of mental health activities to ensure that her project reached students with a variety of learning styles.

Violence-prevention efforts can support a school's institutional goals. A principal noted that the violence prevention/mental health project in her school (1) gave her the crisis response mechanism her school needed for a city-mandated safe schools plan; (2) became a "prominent part" of the state-mandated school improvement plan; and (3) reduced the number of behavior problems in class, which in turn reduced the number of students designated as needing special education—a goal of the state-mandated consent decree governing school improvement. A principal at another site said mental health counseling enabled his school to deal with a dramatic increase in disciplinary referrals after a new state law enabled teachers to expel more students from class.

Successful integration of violence-prevention and education efforts and collaboration among school and mental health staff, even on a small scale, generates far-reaching effects:

• Teachers in Baltimore said the training they received in conflict resolution, although designed to help them understand their students' involvement in peer mediation, gave them tools they now use in their classrooms to defuse fights.

• A school counselor in Baltimore who received peer mediation training used her new skills to teach two sets of feuding parents how to articulate their anger and listen to their opponents' concerns. She was rewarded when she observed one of the parents using the same techniques with her daughter.

• Another school counselor who received peer mediation training developed a conflict resolution curriculum for teachers to use during homeroom "advisory" periods.

• Collaboration with school services enabled one project to reach students who lacked parental consent for counseling and to provide extra support for school health staff. Mental health staff at San Fernando can provide crisis intervention counseling to students who do not have signed parental consent forms if they are assisting the school nurse or staff from the district-mandated IMPACT intervention program, and if the school nurse or IMPACT staff member is present during counseling. Mental health staff also help IMPACT teachers resolve cases they feel are beyond their expertise—such as potential suicides—and file child abuse reports with the county department of protective services. In exchange, IMPACT has provided the mental health program with limited classroom space for counseling sessions. These arrangements supplement and expand the services of both programs.

Coordinating School and Mental Health Practices and Systems

Most sources observed that schools and mental health projects have slightly different goals and expectations that, without attempts to coordinate efforts, can cause turf issues. Although both have the best interests of students at heart, schools and health care systems are innately different. These philosophical differences, which can produce conflict between counselors and teachers, make coordination tricky but essential. Schools, like most institutions, assume that effective operations require a calm, settled atmosphere. But mental health therapy is based on shaking up deep-seated emotions, providing stimulus rather than discipline, and encouraging change. As one counselor explained:

The school's purpose is to contain and control, and our purpose is to release and open up and empower kids. That in a nutshell is the nature of the conflict.... Teachers are stressed out, demoralized [by a recent pay cut]. Their emphasis is on education, not [health] services.

Special constraints that seem natural to schools can create misunderstandings with school-based providers. Schools operate under pressures that non-school staff may not immediately understand. For example, teachers are expected to work closely with parents, teach a prescribed curriculum, maintain classroom discipline, coordinate multiple special education needs, and help students meet education standards. "They don't have the luxury of focusing their attention on just one student at a time," a school guidance counselor explained. Education programs such as Title I and special education, which serve many high-risk students, also carry requirements to which schools must respond. And although principals are the obvious education leaders on campus, they may not always be the final decision makers; ultimately, they must answer to a superintendent and school board. "Without understanding [the rules and

hierarchies], both teachers and counselors can be frustrated," a guidance counselor said.

This environment makes the school setting ripe for misunderstandings between mental health and education providers. As the sites in our sample found, misunderstandings can be as subtle as a health provider administering a survey without first obtaining school approval—or a teacher who, interrupted by a summons to release a student for counseling, crumples up the summons and throws it away. Conflict between providers also can be overt. At one site, students are required to write formal complaints when they feel they have been harassed by school personnel. Because many students are poor writers or do not speak English well, they ask the mental health counselors for help. A school administrator recently accused one of these counselors of ghost-writing the complaints for students—a charge that did not help the relationship between the clinic and the school.

Schools and health care providers follow different legal protocols that can create discord. Differing confidentiality protocols present the biggest obstacle to coordination. At San Fernando High School, for example, the school district policy on reporting child abuse requires school personnel to contact the school nurse, who makes a note on the child's record, in addition to the county department of protective services. The counselors at the school-based clinic, however, are only required to report abuse information to the county—not to the school or school district. Similarly, school personnel who discover that a student has suicidal thoughts must fill out a special referral document, inform the student's parents, and keep a record of the information on-site; school personnel may be informed on a need-to-know basis. Again, mental health clinic staff do not need to inform the school or school district.

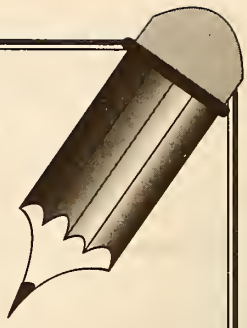
By following separate medical protocols, the mental health staff may appear to be flouting the school's desire for shared information—at one site, teachers described a counselor as "too secretive"—but breaking confidentiality compromises the medical ethics that guide mental health counseling. Confidentiality differences can aggravate turf barriers because they accentuate the differences between stakeholders rather than the common interests that guide their activities. One solution, proposed by a district coordinator of school-based health at one site, may be to establish protocols for informal information sharing among certain staff members, on a need-to-know basis.

Schools have conflicting responses to violence issues because they are concerned about their public image. This ambivalence can hinder efforts to develop collaborative mental health or violence prevention projects. School leaders—under constant pressure from district administrators, parents, community members, politicians, and the media to eliminate violence—have some interest in downplaying the existence of school violence. At one site, this tendency conflicted with the health providers' interest in publicizing needs that had to be addressed. When the clinic manager offered an assessment of school violence at a teachers' meeting, school leaders believed the mental health workers had betrayed the school's trust. To resolve the conflict, the program manager, her supervisor, and the principal met to discuss their concerns. The open communication reduced everyone's fears that there would be negative consequences of sharing information and confronting real issues. At another site, a principal was upset when a school health director shared information with a news reporter. Now, the clinic channels all media requests to the school district or a health center liaison.

Some teachers see mental health counseling as unnecessary competition for class time or other school priorities, such as sports. Sources said the loss of class time may be especially frustrating for science teachers, whose instruction and assignments are organized around lab experiments that are available only at certain times, and

Tips from the Field:

Resolving Philosophical Differences between School and Health Staff



1. Initiate direct, personal contact between the affected teachers and health care providers to resolve overt conflicts. "Most of the time, we're faceless—just a slip of paper" requesting a student's release from class, explained a counselor. "Personal contact makes a difference."

2. Don't be afraid to ask school, school district, or health center leaders to mediate a problem. They all have an interest in maintaining services in the least disruptive manner.

3. Seek opportunities to educate your counterparts about what you do. For example, have counselors visit a health class to explain the services they offer and to let teachers know that the extra resource exists. Encourage teachers and mental health providers to interact with the medical providers at the school-based clinic so they are aware of the psychological needs of students as well as their health conditions. "Medical staff need to see (mental health) services as complementary and equal" to their efforts, a counselor said.

4. Respect each stakeholder's position. In particular:

   - Be willing to adjust priorities and learn from your counterparts
   - Establish systems for dealing with media inquiries that keep all parties informed and unified
   - Encourage flexibility and communication among and between staffs, both informally and through group meetings

5. Whenever possible, reduce competition by emphasizing a team approach to helping all students become healthy and educated, rather than accentuating philosophical differences between educators and health professionals. Try to understand your counterparts' professional problems, too. For example, when teachers at one school went on strike, health clinic workers visited them on the picket line to talk and bring items they needed. When the strike ended, the teachers and health workers shared a friendly relationship.

for math teachers, who must proceed through certain instructional sequences. In these situations, counselors have learned to explain that mental health services can take a burden off teachers by providing students with the support they need to learn. "[Releasing students from class] is a problem if you want everything nice and neat and on schedule," said one veteran teacher. "But it's rare that you're going to have everything in neat packages. If they're not getting counseling, they're going to be out of class anyway because they're not functioning."

Despite the innate differences between schools and clinics, many educators welcome mental health services and view them as part of larger education initiatives. For example, the principal of San Fernando High School views it

as his responsibility to provide multiple options and services to students, even at the risk of straining the school system, because cultural constraints will prevent his Latino students from obtaining mental health services outside the school:

They will probably only talk to their priest or boyfriend, if anyone. For girls, that leads to dependence on a male figure. For boys, [seeking help from their peers] can lead to gangs.... If I can offer 10 programs, will it put a strain on the school? Absolutely. But will it affect kids? Eventually.

Teachers typically say that having a school-based mental health provider available takes a burden off them by offering a resource for problems beyond the teacher's expertise and by defusing classroom disruptions. Teachers are likely to seek help from mental health staff for on-going problems as well as crises. For example, a teacher with a grieving student in her class said she has urged him to seek counseling so he can concentrate on his school work. With the school-based counseling program in place, she says, "There's a place to send him. Otherwise, what would I do? It gets complicated way beyond our training."

Building Support and Involvement Among Stakeholders

Project staff at all three sites have learned to address differences in philosophy, protocol, and priorities by cultivating broad involvement and by facilitating communication among all stakeholders. Principals, teachers, school counselors and nurses, and some district personnel have an especially strong interest in the operation and success of a school-based violence prevention project—and mental health providers rely on these stakeholders for referrals, space, and general support.

District-level support is especially important. Solid backing from school district personnel builds community support for violence prevention/mental health projects and can foster support from leaders within the school. Districts that feel positively about projects may provide additional space, public relations, or other resources that the project or school could not obtain alone. The project director at one site benefits from a strong working relationship with the district's liaison for school-based health services, who negotiates public relations for the project, obtains and maintains funding, secures space for mental health providers, and helps smooth out conflicts between clinic staff and district personnel. Project directors at other sites agree that this high-level support is essential.

With support from key school leaders, a violence prevention/mental health project can flourish; without this support, the project languishes. Project directors at all sites highly recommended involving key school leaders and staff in the planning process and in the early phases of implementation. As one project administrator noted, "We even had the principals and educators involved in the hiring process. We tried to keep all the players involved...We felt that they [schools] were going to be seeing the counselor more than we would, so they have to have a say." At another site, cultivating active support from administrators during planning was more difficult because the school was undergoing restructuring and the new administrators faced competing demands for their time and attention. This site continues to struggle with project implementation.

The support of principals is especially important during implementation because school leaders set the tone for coordination among all school staff. "Without the principal's support, things don't fly. Teachers are going to follow the direction they're given by their principal," a health provider observed. A principal's support may be especially important for projects that rely on teachers' participation, such as the peer mediation project at Thurgood Marshall Middle School. As the project evaluator noted, successful peer mediation requires adequate time for teachers to supervise, mentor, and support

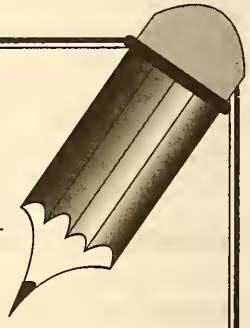
students as well as promotion of the program throughout the school. Teachers must be informed of the program, understand how to assess students' need to participate, and know how to refer students for participation. Principals must support these efforts by scheduling time for peer mediation training and making rooms available for mediation sessions. Principals also have control over disciplinary policies, which may or may not refer students to peer mediation; these policies have a direct impact on students' incentives for participating in the mediation process.

To generate support from principals and other school leaders, health providers recommend taking time to lay a foundation of support before implementing a violence-prevention project. Key strategies include obtaining written and verbal support from school administrators; making sure both sides develop a clear, concrete understanding of all of the project's elements; and scheduling regular planning and implementation meetings with principals.

Active involvement from teachers builds a project's legitimacy and ensures that students who need mental health or violence-prevention services receive them. At one site, some teachers have supported the violence prevention effort through referrals and by arranging a party to celebrate the first anniversary of the project. At another site, mental health providers refer and receive referrals from teachers who volunteer for a school-sponsored counseling program. The teachers, who receive some training from the district, focus on substance abuse and grief issues; the mental health professionals handle more serious cases requiring clinical training. The coordinator of the school program shares office space with the school-based mental health clinic and talks informally with mental health staff to arrange referrals. This type of support from faculty increases the likelihood that the program will continue and takes some of the burden of maintaining the project off the shoulders of school-based clinic leaders.

Tips from the Field:

Lay the Groundwork for Broad-based Project Planning



1. During the earliest stages of planning, decide who will directly supervise mental health staff, resolve space issues, and establish protocols for maintaining confidentiality and for sharing information among school and health staff.

2. Solicit input from multiple stakeholders in identifying the qualifications that school-based mental health staff should have, what their responsibilities will be, and how the mental health staff should interact with the school.

3. Make sure health providers spend time networking with educators and school administrators on the campus, before the program is implemented, to familiarize school staff with the project. Ask the school counselors how the new project can support their efforts and how they would like to divide up the counseling territory.

4. Don't underestimate the amount of time planning requires. Take time to participate in school-related meetings where you can share information and elicit support.

Delineating separate roles and responsibilities for school and mental health staff removes turf barriers, promotes coordination, and streamlines referrals. School and district policies that define roles for school counselors, nurses, and psychologists can help school and project staff avoid stepping on each other's toes. Sites in our sample defined roles according to staff expertise, background, interaction styles, and schedules. For example:

- The IMPACT program at San Fernando High School is authorized by the district to treat students who have general mental health or substance abuse treatment needs or who lack parental consent for counseling, while the violence prevention project takes responsibility for crisis intervention and complicated cases that require more expertise in counseling.

- In East Hardy County, the violence prevention counselor is viewed as having a more confrontational counseling style than school guidance counselors, making him better suited to tough behavioral, psychological, or drug abuse cases. A school guidance counselor, who previously had an 18-year career in social services, handles physical abuse and neglect cases as well as more academic needs. Another guidance counselor is trained only to work with students in kindergarten through sixth grade, leaving the seventh- and eighth-graders entirely to the violence prevention counselor.

- The violence prevention counselor in East Hardy County handles cases that require long-term, regular counseling because he has more control of his schedule than the school counselor does; the principal is less likely to appropriate his time or call him away to other duties.

- The San Fernando clinic's year-round schedule, ability to meet with students after school, and ability to provide family counseling give it a special role in treating cases that require flexible or uninterrupted counseling.

Ideally, school counseling staff, principals, health center leaders, and other stakeholders meet during the planning process to establish clear guidelines for the role of the school-based mental health counselor. This was the case at the West Virginia site, where planners assessed the limitations of existing school counseling (e.g., not available evenings and summers, limited control over the counselor's schedule, subject to school district demands, mixed academic counseling demands with mental health needs, unable to establish regular counseling sessions because of school schedule) and defined the violence prevention counselor's job to address these needs. This process clearly defined differences in the roles of school and health staff.

Many practitioners credit a formal structure for communication during the planning process, such as monthly group meetings, with promoting the investment of all stakeholders and addressing specific issues. "Communication is absolutely imperative to understanding each other's systems and ground rules," noted a school nurse who facilitates referrals to a mental health counseling program at her school. Our sites found that the burden is on the program coming into the school—the mental health component or the school-based clinic itself—to initiate communication with school staff, especially by making the school aware of any decisions about staffing or service delivery that could affect school practices.

Through regular communication, the various stakeholders concerned with children's well-being learn to recognize each other's strengths, weaknesses, backgrounds, training,

and experience. This knowledge guides them in referring students and in seeking advice from colleagues—activities that strengthen the relationship between education and mental health services. Without this knowledge, teachers may be less likely to refer students to the violence prevention/mental health services. "I would probably use [the counselor] for a special event or presentation, but I don't really know how to fit him in," said a teacher at one site.

Similarly, informal communication among stakeholders during implementation builds understanding among educators and health professionals, reduces turf barriers, increases access to services, and facilitates referrals. Informal, personal contact enables mental health providers to develop credibility and educators to develop trust in a counseling or violence-prevention project. Without personal contact project staff are "faceless," explained one mental health provider. But a teacher who communicated frequently with a school-based counselor said, "I trust his judgment and if he tells me he needs a student, then I know it's important enough [to let the student miss class]."

Informal interaction is also particularly well-suited to the hectic and unpredictable nature of schools. A counselor who speaks informally with principals every day when time permits says that a formal discussion process would be "too rigid" and would fall prey to the spontaneous demands of the school. However, informal communication may be easiest in small, rural schools and communities where the various stakeholders tend to see each other outside the school environment and where there are fewer entities that require coordination. In urban settings and in larger schools, health and school staff may have to work harder at networking or rely on more formal mechanisms, such as faculty meetings.

An ongoing mechanism for coordination among school and mental health clinic staff can increase awareness of students' needs and facilitate collaboration. For example, a 20-member crisis team at San Fernando enabled educators and health professionals to coordinate their responses to violence prevention and crisis intervention. Although some schools seek to downplay situations that could hurt their public image, this school found that the crisis team offered a useful, coordinated response to violence without diminishing the school's reputation. The team, led by an assistant principal with guidance from the mental health clinic's psychologist, provided school staff with information on gang incidents and accidents in the community that might affect students' physical or mental health. The team also devised immediate, collaborative responses to these crises and brought in outside speakers to discuss community resources. Mental health clinic staff used the team to explain how crisis intervention works and how it can be coordinated most effectively; this helped spread the responsibility for crisis intervention among many stakeholders.

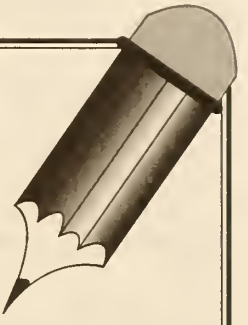
Since the crisis team disbanded in 1995-96, when the assistant principal left the school, teachers say they know less about the factors affecting students' mental health and must rely on personal contact with counselors to meet students' needs. Now, monthly meetings with the principal, school nurse, mental health staff, school-based health clinic staff, and school district's nurse supervisor promote communication and coordination.

Outreach to community, faculty, and students improves communication and coordination with stakeholders. All sites found that conducting outreach through assemblies, printed materials, announcements, or presentations informed stakeholders about the services, goals, and purposes of the project. Information can ease parents' minds about potentially controversial treatment issues, encourage staff to make referrals, and involve school community members in project activities.

At most sites, faculty outreach is accomplished through collaborative working arrangements. For example, a mental health counselor at San Fernando High School visits classrooms at teachers' requests to talk about issues such as divorce, death, and grieving; she also describes the mental health professions during the school's career week. A counselor at another site visits classrooms on request to teach students about self-esteem, goal setting, and relationships.

To address community concerns, sources suggested (1) involving as many people as possible—parents, teachers, and older students—in every stage of program planning, including hiring; (2) disseminating information via mail, radio, or newspaper that reassures community members by addressing sensitive issues head-on; and (3) involving potential detractors in planning to avoid turf battles within the school and with private providers in the community.

Tips from the Field:
Reaching Out to High-Risk Students



1. Don't hesitate to ask questions about a student's sexual orientation, possible abuse, or thoughts of suicide. These are difficult topics for students to talk about, but by raising the issues a therapist lets the student know he or she can handle any knowledge the student chooses to share. "They may not say anything right away, but...if they know you're willing to listen, and you ask, they'll come to you when they're ready to talk," a counselor advised.

2. Encourage mental health and violence prevention professionals to dress casually—not in "stuffy" clothes that place psychological barriers between them and the students.

3. Allow counselors to mirror students' language and to share stories of their own difficulties, when appropriate. It's easier for students to trust and open up to mental health professionals who obviously relate to their problems.

4. Because mental health counseling forces students to confront difficult issues and can seem invasive, use analogies that help children understand why therapy and crisis intervention are important. One counselor tells students therapy is "like getting to the heart of an onion—you have to peel off many layers of hurt to fix the problem."

5. Because many at-risk students—especially those who have been abused—do not trust adults, focus on building trusting relationships with students. Before asking a student to fill out paperwork for mental health services, for example, describe the confidentiality rules that govern mental health staff. Make sure the student understands conditions under which his or her information must be shared with parents, police, or county agencies before filling out any forms required for services. Students may feel betrayed if a counselor has to share confidential information after the forms have been filed.

6. Be aware that a confrontational style may be necessary to reach some students, but it can stir up problems. "If you're doing your job right and asking the right questions and making kids appropriately question their parents...there are going to be problems," said a counselor whose "problems" included a death threat. "Just don't take it personally."

Outreach to students is important, too. Students who do not know about the project's services, do not understand the purposes of violence prevention or mental health activities, or do not feel encouraged to be a part of the project will stay away. The fact that students at one site said only 25 percent of their peers are aware of the mental health services shows that providers cannot rely on student word-of-mouth or referrals from adults to bring in all the students who may benefit from violence-prevention services.

Outreach can be difficult to incorporate into a school-based project because (1) the

Tips from the Field:
Integrating and Coordinating Education and Mental Health

1. Make sure that school counselors, nurses, and other health-related staff know that the new program will complement their work—not diminish their importance in the school.

2. Make sure health staff understand the school bureaucracy. Avoid institutional roadblocks by seeking consensus on issues, perhaps through formal advisory groups or staff meetings.

3. Orient new mental health staff to school staff and policies so they learn how to work with the hierarchies, conventions, and systems in which they are located.

4. Encourage health staff to build mutually supportive relationships with school staff. This includes office assistants, cooks, and custodians as well as teachers. After taking advantage of a fire drill to introduce herself to three school administrators, one clinic psychologist found she received better feedback on student progress as well as "the real scoop" on violent incidents on campus. Another counselor asks students to introduce her to their teachers.

5. Involve key violence-prevention staff in school committee meetings to make sure both school and counseling staffs are updated on issues and circumstances.

6. Without betraying confidentiality, inform teachers in advance when you know a student must miss a class, so teachers don't worry about unexpected student absences.

7. Send thank-you notes to teachers after every referral, acknowledging their role in facilitating mental health care and explaining confidentiality policies.

8. Hold a thank-you brunch for school staff. This promotes informal networking between health and education staff and reiterates the importance of referrals from teachers.

9. Consider offering workshops to help teachers deal with their own stress and to teach them skills for confronting violence without losing students' respect.

10. In cases linked to disciplinary actions, consider providing release time for teachers to meet with the counselor and student, to prevent students from playing teachers against counselors.

hectic, crisis-driven nature of mental health needs places a greater emphasis on treating immediate problems and (2) schools may have conflicting views about mental health services or may view the project as separate from the "real" process of education. One solution is to coordinate mental health outreach with similar efforts conducted by school programs, such as a school health office or district-operated intervention program. In San Fernando, mental health staff participate as presenters at an annual in-service session, conducted by IMPACT, to increase faculty awareness of mental health needs. Collaborating reduces the administrative burden on the mental health clinic, provides a mechanism for outreach that is already accepted by the school system, and—because teacher participation is mandated by the district—ensures that all teachers receive information on the mental health services.

Parent, Family, and Community Involvement

Parent and family involvement at most sites ranged from minimal to moderate. All projects provided family counseling or referrals when required, and one site reported frequent telephone contact with parents to advise them on their children's problems, requirements, or medications and to suggest non-violent methods of punishment in discipline cases. Several factors hinder parent and family involvement at the three sites, including:

- Large distances between the home and school
- Long workdays that make it difficult for parents to visit the school, schedule after-school counseling sessions, or pursue referrals for outside services
- Parents' negative experiences with school or suspicions about mental health counseling
- Strict requirements that parents entering the schools obtain passes and clearance through locked doors, which discourage visits
- Limited staff time for counselors to follow up on family circumstances
- Family apathy, or a tendency to seek help only when in crisis, which makes preventive care difficult

In addition, mental health services have offended some parents (although this problem does not appear to occur frequently). For example, when one student who had received counseling for sexuality issues informed his family that he was gay, his parents accused the school-based mental health counselor of "making" the youth homosexual.

Mental health providers view community involvement as a double-edged sword. Community resistance to some elements of mental health or violence prevention services can limit program options. In East Hardy County, school-based health staff are not allowed to discuss sexuality or sexual issues openly at the middle school because of community concerns, which limits their ability to identify some cases at an early stage or provide more preventive services. But a history of outreach or community involvement can facilitate a relationship between the mental health project and schools. For example, before the E.A. Hawse Health Center designed its school-based violence-prevention project it had helped the school obtain a state grant for fitness equipment—a collaborative effort that surprised and pleased school staff and served as an icebreaker for future collaboration.

Communities with large schools and limited resources especially welcome school-based mental health services. In a rural area where the elementary school counselor has a case load of 1,200 students and the school nurse must divide her time

among four schools, school staff have a clear incentive to work with the mental health provider. "He'd be the first one I would call [for help] because I know the school counselor is divided throughout the county," a regional health coordinator said. School counselors at another site, who serve between 400 and 500 students each, agreed that they depend on the clinic's mental health provider to meet the demand for services.

Cultural Responsiveness

School-based clinic staff and administrators at all three sites were aware of cultural issues that affected mental health/violence prevention services, staffing, or practices. Common to all sites are cultural attitudes among students that deter them from seeking mental health care or participating in violence prevention activities. In San Fernando, Latino students and their families value privacy and shun mental health care, which is viewed as a sign of weakness. Recently immigrated Latino students may not seek mental health care because of language barriers. Students living in Appalachian Hardy County come from a rural culture that also values privacy and distrusts outsiders. At Thurgood Marshall Middle School and San Fernando High School, students are immersed in a street culture of gangs and neighborhood violence that encourages dangerous behavior and discourages asking for help or walking away from conflict.

At all sites, project staff respond to these cultural issues with a variety of strategies:

- At San Fernando High School, a bilingual intern and counselor offer group and individual sessions in Spanish; recently arrived immigrants can participate in focus groups on acculturation issues.

- Also at San Fernando, mental health providers plan to offer a student group for gang members in collaboration with the school's IMPACT staff, who have experience working with gangs.

- At Thurgood Marshall Middle School, project leaders replaced the original student mediation trainer with a new trainer who can better relate to students' experiences on the streets and in neighborhoods. While the first trainer failed to engage students and faculty, the second trainer has elicited stronger support because he has first-hand experience in students' problems and acts as a positive role model.

- Because gossip is rampant in small, rural communities, the mental health provider in East Hardy County is careful about socializing with colleagues or community members in order to prevent the unintentional disclosure of information about students. Although this protects student confidentiality, however, it can hinder efforts to build trust and credibility.

Financing, Assessment and Accountability, and Results

Key topics in this section include funding and reimbursement; self-assessment, accountability, and evaluation; and evidence of success.

Funding and Reimbursement

Each site received $100,000 in fiscal year 1993, $25,000 in FY94, and $25,000 in FY95 from the HRSA BPHC. Each site supported its violence prevention/mental health project solely with this special grant. The primary costs were for salaries; in each case, the school system provided space, utilities, and, in two cases, telephones (although not always the telephone line). None of the sites charged students for mental health care, although two sites pursue Medicaid and/or third-party reimbursement when possible.

Sources identified the following funding and reimbursement issues:

- **Restrictions on billing for services limit reimbursement opportunities for some counseling projects and cultivate dependence on grant funding.** Under West Virginia law, for example, the health center cannot bill for counseling services provided at any location, including the schools. The health center has asked for a state waiver that would allow billing for counseling, which administrators believe would help make the mental health counseling project self-sufficient and sustainable.

- **Medicaid managed care threatens to destroy the revenue base of some school-based mental health care programs.** In San Fernando, the school district and health care provider are concerned about California's pending shift to managed care because school-linked and school-based health services have not been identified in proposals as accepted medical homes for students. Health staff say that because students' families do not take a proactive role in health care, they are unlikely to choose their medical provider under managed care; instead, many students will likely be assigned a medical home far away from the school-based clinic. The clinic and the mental health program may not be able to seek reimbursement for services provided to these students.

"I'm damn worried. If our school-based mental health services can't be included in managed care, we'll lose them," said the district liaison for school-based health services in Los Angeles, where 92 percent of children are uninsured or underinsured.

- **Because successful counseling requires the long-term development of trust and credibility, continuity is essential to successful mental health counseling. Continuity is threatened by a lack of stable, sufficient funding.** "We need continuity in the mental health aspect even more than in the physical [health care services]," a school superintendent explained, because issues such as domestic violence and lack of self-esteem require rapport between counselor and student—and rapport is only established over time. "The thing I hate is opening a program, then you run it a few years, and then you have to close it down," agreed a health care provider. "You have to be [especially] cautious of that in a small community

where everybody knows everybody and is related."

• **Mental health services and staffing are extremely vulnerable to funding cuts.** "Without the [HRSA BPHC] grant, the interns would not get a stipend and it would be even harder to attract long-term, bilingual [staff]," said one project leader. "Something is going to have to give somewhere; if I keep [one staff member], I'll have to give somewhere else."

• **Concern about long-term sustainability has motivated health centers to aggressively pursue all funding opportunities and cultivate outreach efforts.** The director of school health at E.A. Hawse Health Center, for example, is applying for every grant she is aware of—including a portion of the state's $7.5 million block grant for substance abuse prevention. The school health director also is participating in a new regional planning group on substance abuse with the hope that it will stimulate interest in counseling and violence prevention in other schools and counties.

Self-Assessment, Accountability, and Evaluation

At the sites in our sample, self-assessment practices ranged from monthly reports of encounters to a two-year evaluation that was written into the project design. All three sites collect process data, which they use to inform program design or to attract and justify funding:

• The mental health provider at the East Hardy County site gives a monthly report of encounters to his administrative supervisor at the health clinic. The report assigns each encounter a coded risk factor (e.g., family problems or drug abuse) along with the student's name, age, gender, and grade level. The health administrator uses the reports for grant planning and incorporates the data into speeches she gives at violence prevention conferences to increase public awareness of the project. Administrators also hope to use the data to estimate the revenue potential of services.

• In San Fernando, where there are many mental health providers and a large student population, project staff collect process data using the School Health Online!!! information management system. Staff compile data on client demographics, patient encounters, diagnoses, and referrals. These data are used to generate quarterly reports for the school district's coordinator of school-based health clinics, who uses it to attract and justify funding. Project staff use data on the days of clinic/patient contact and the number of attempted contacts for program planning. Self-assessment also occurs at weekly mental health staff meetings, when the counselors, consulting psychologist, and interns discuss specific cases, therapy approaches, and issues involved in coordinating the health and education systems.

At these two sites, data collection for accountability was addressed during later stages of implementation and viewed as less essential during planning. In contrast, the Baltimore project included an evaluator from the beginning of the planning and implementation process. The evaluation at this site included (1) questionnaires, submitted to teachers and counselors before program implementation, designed to collect baseline data on physical violence and verbal abuse from and between students, including classroom disruptions; and (2) interviews and questionnaires to assess the program's impact on students. All interviews and questionnaires focused on changes in student behavior—not knowledge—due to the violence-prevention efforts. The first

round of questionnaires asked teachers to rate violence in the school and to identify the number of violent incidents they had witnessed in the school. The evaluator distributed a second questionnaire a year after implementation that asked teachers to rate the level of violence in the school, identify the program's impacts, and suggest changes that could improve the program. Interviews conducted with student leaders—some of whom participated in peer mediation and some of whom had only the classroom violence-prevention curriculum—gathered information on the personal impacts of the project on the lives and behaviors of students.

Sources at the Baltimore site identified two key issues affecting assessment, accountability, and evaluation:

- ***Quantitative measures of success can be difficult to obtain in a school setting.*** Initially, planners wanted to compare Marshall with a control school that had comparable disciplinary and violence incidents. But the school restructuring at Marshall had created a new administration, with new principals; divided the school in half; and established new policies that reduced disciplinary suspensions. These changes made it impossible to compare circumstances before and after implementation of the violence prevention program or to compare Marshall with a control school. Instead, the evaluator relied on anecdotal data.

  Now that the school administration has remained constant throughout implementation of the violence-prevention program, the evaluator may compare attendance rates, suspensions, or police reports filed before and after implementation (assuming policies and practices have been consistent). However, gaining access to school records may be difficult. Although the sub-schools collect some data (e.g., number of disciplinary actions, mediations, and results of each mediation; school suspensions; dropout rates), the school-based clinic does not have access to this information. One principal said her school keeps the information only in students' individual files and does not compile aggregate data.

- **School cooperation is essential to effective assessment and evaluation.** Schools that do not have the time or inclination to help can make it difficult for outside evaluators to gain access to students and teachers for interviews or surveys. Schools may also specify which staff members evaluators may or may not interview. Project staff may have to act creatively to overcome these barriers to information collection. For example, when teachers at Thurgood Marshall Middle School failed to respond to the evaluator's first questionnaire, the clinic sponsored a catered luncheon and used the questionnaire as a meal ticket. Ninety-eight percent of teachers responded.

Evidence of Success: The Results of Violence Prevention Efforts

Although anecdotal evidence abounds, evaluators of school-based violence prevention and mental health projects struggle to find quantitative measures of success. Quantitative evidence is hard to identify for several reasons. A multitude of variables affect student outcomes, making it difficult to pinpoint results. Counseling and conflict resolution agendas are slow-acting; they lay a groundwork for behavioral change than may not be measurable until many years later. At-risk students are transient, so comparison groups or schools are generally not feasible. And with limited time available, the overworked staff at most school-based health clinics believe they must choose between addressing health crises and collecting data; data collection usually falls by the

wayside. "We know we are making a difference, but we don't know how, exactly," one administrator conceded.

Sources at each site suggest investing time in trying to develop measures of success, however, because evidence helps implementers know whether or not their project is achieving the intended results and also helps them adapt program design to maximize success. In addition, evidence of project success is meaningful to potential funders. Ideally, evaluations use multiple measures of success, rather than relying solely on either quantitative or anecdotal evidence.

Despite the impediments, sites that received the special violence prevention grants identified some measurable impacts. Most were process indicators rather than outcome measures. These included:

Outcome Indicators

- Fewer suicide attempts or incidents of fighting on campus
- Improved attendance among previously truant students and those with chronic discipline problems

Process Indicators

- Increased student visits to the school-based clinics for mental health services
- Reduced waiting time for services
- An expanding clientele for mental health/violence prevention services
- Increased referrals to school-based mental health services

The sites also reported strong anecdotal evidence of success, including:

- Individual success stories—cases in which counseling enabled specific students to stay in school and resolve their own problems or prevented a crisis by identifying a problem at an earlier stage
- General improvements in student attitudes and behavior in the classroom and hallways, as observed by teachers and principals
- The use of newly learned conflict resolution tools by students, as observed by teachers, principals, and school counselors
- Improvement of students' readiness to learn, as observed by teachers
- Greater awareness of students' mental health needs among school staff
- A greater sense of school safety among teachers and students
- A reduced level of stress among teachers
- An increase in positive interactions between education and health providers
- Positive attention from parents, the community, the media, and/or other schools

Peer Mediation Taught a Former Fighter to Walk Away from Trouble

Thirteen-year-old "Diondra" used to get in lots of fights. But after she received peer mediation training, she began to find new ways to resolve her conflicts. One day, she and a friend were walking past another girl's desk when Diondra's friend bumped the desk. The third girl's camera fell off the desk and broke. Thinking Diondra was at fault, the girl yelled at her to pay for the damage. "I just walked away," Diondra recalls. "She confronted me in the hall outside class, and I just walked away again." Even though this situation was resolved in the principal's office—not through a peer mediation—the conflict resolution skills Diondra learned during mediation training enabled her to defuse the situation. "Without the peer mediation, I would have gotten angry and not walked away," Diondra says.

Health care providers view school-based violence prevention/mental health efforts as a way to increase access to health care for hard-to-reach populations. Teachers see the efforts as a way to improve students' readiness to learn. Some principals focus on the projects' potential as a disciplinary tool. School district representatives in cash-strapped areas, and school counselors or psychologists with heavy workloads, focus on these projects as a way to augment the essential services that their schools provide. Despite these differences, the basic criteria health and school staff use to assess the results of school-based violence-prevention efforts are remarkably similar: individual changes in behavior, as observed by school staff or documented in therapy; a decrease of violence on campus; and the presence of students in school and in counseling, indicating their sense of safety.

The Spillover Effect of Training Some Students in Mediation Encourages all Students to Use Conflict Resolution

"Harry," a 14-year-old eighth grader at Thurgood Marshall Middle School, had heard about mediation techniques from his friends but had not received formal training. Nonetheless, when he saw two boys arguing in the hallway outside a classroom, he stepped in. Profanity filled the air, and the boys—fighting over ownership of a pen—were close to physical violence. "I'm not going to let you guys disrupt this teacher's class," Harry insisted, and he urged the boys to schedule a peer mediation session.

"[Harry] saw himself as a go-between, a knight in shining armor," recalled a teacher who witnessed the intervention. "Without the mediation [project] in place, this would have just simmered. Sometimes kids hold these grudges all day; then it explodes after school."

Sources emphasized that the results of violence-prevention efforts are often gradual and hard-won. "We did not expect results for several years because these are difficult, intricate goals," one administrator said. "You can't change behaviors overnight. But we felt that if we could get to younger children, we would hopefully prevent them from getting into those behaviors."

Now, as the sites begin to see some progress toward their initial objectives, planners are beginning to address new goals—especially that of sustaining their projects after grant funding expires. "Our goal now is to figure out how to keep doing what we're doing without any funding," one school health director said. Health center and clinic staff have also realized how integral mental health services are to meeting the other goals of health providers. As an administrator explained:

> *We're so involved in increasing primary health care and getting families in there, we forget so many of these kids' problems are rooted in mental health.... We can keep throwing condoms at them, but the truth is if they get pregnant because they want someone to love them and they want to get out of their house because they really hate it there, we're treating the symptom but not the cause.*

Recommendations from the Field

When asked to create a "wish list," school, health, and mental health staff suggested the following components for an ideal school-based mental health collaboration:*

Services and Resources

- Long-term counseling, with at least one full-time counselor per school; a combination of individual and group counseling plus peer mediation services
- Direct access to a psychiatrist who can prescribe medications and provide guidance on severe cases; on-site social workers to coordinate resources
- Treatment for truancy, depression, and other pervasive but non-crisis needs
- Comprehensive services that reach beyond the campus to involve community resources
- Adequate space to afford immediate treatment, privacy, and a drop-in area where mental health care can be incorporated with recreational activities; one site also proposed creating a permanent, school-based peer mediation office
- Time and staffing for a home visiting/counseling service to address domestic violence
- Support for students with Attention Deficit Disorder and learning disabilities

Strategies

- Coordination with a violence prevention law, such as West Virginia's Safe Schools Act, and a corresponding enforcement policy, which strengthen school-based efforts
- Education of students, school staff, and parents about violence-prevention policies
- Programs or presentations on conflict resolution, tolerance, and cultural diversity aimed at educating students, parents, and school staff; training materials, films, and special events focusing on peer mediation and cultural diversity
- Family involvement, especially through case management

Integration and Coordination

- School curricula on violence prevention, conflict resolution, and good parenting practices—taught in every grade—that help students understand the behavioral choices available to them and teach tools for avoiding and resolving unhealthy relationships. Counseling, beginning in kindergarten, that focuses on positive attitudes and self-esteem
- Time in the school schedule for clubs and associations in which students can share common goals, work together, and experience unity rather than conflict

*This is a compilation. Not every source endorsed every suggestion.

Appendix: Case Studies

Baltimore Medical System, Inc., and Thurgood Marshall Middle School

Baltimore, Maryland

- A project combining a violence prevention curriculum, peer mediation, and mental health counseling laid a foundation for developing students' conflict resolution skills
- Although concurrent changes in the school—including restructuring into three sub-schools on a single campus—hindered early implementation, school and health staff are working together to resolve difficult issues
- Evaluation based on questionnaires and interviews with teachers and students provides valuable feedback on services, activities, and impacts

Overview

A mixture of three distinct services—individual and group counseling, a conflict resolution curriculum delivered in classrooms, and a peer mediation program that included faculty development—targets both violence prevention and crisis intervention, accommodates a variety of learning styles, and attempts to integrate violence prevention into the school environment.

Number of students served: 1,100 enrolled in three sub-schools. In 1994-95, the clinic recorded approximately 300 encounters for counseling, 360 students receiving classroom-based violence prevention education, 430 encounters for a "life planning" group session, and 660 encounters for mental health screenings at a school health fair
Grades served: 6-8
Racial/ethnic breakdown: 92% African American; 7% Anglo; 1% Asian, Native American, or Hispanic
Percent eligible for free or reduced-price lunch: 71%
Major sources of funding: Violence prevention grant from the Health Resources and Services Administration's Bureau of Primary Health Care

School and Community Context

The Thurgood Marshall Middle School campus consists of three entirely separate schools (referred to in this profile as sub-schools), each with its own principal and administration. Two of the sub-schools are located in a single building, divided by a long hallway and a row of doors that must be unlocked and re-locked by a teacher or administrator. A third sub-school, for children with learning disabilities from throughout the city, is located on the campus in a separate building.

Baltimore Medical System, a community health center, operates the Teen Health Assessment and Treatment (THAT) Place in one of the sub-schools at Marshall. Eighty-five percent of the students served by the clinic live in homes where substance abuse is present, and 60 percent have no health insurance. Thirty percent of students receive medical assistance, primarily through HMOs.

In 1991-92, the Thurgood Marshall campus (then known as Herring Run Middle School) recorded 2,082 disciplinary incidents, including 347 attacks on students, 24 attacks on staff, and 12 weapons violations; the school attendance rate was barely 76 percent. (It has since improved to approximately 86 percent.) In 1993, Marshall had the highest arrest rate of any school in the city; the surrounding area had high rates of

adolescent pregnancy, unemployment, drug and alcohol abuse, and other social and health problems. The number of violent incidents that children regularly witness in the neighborhoods surrounding the school continues to increase dramatically. During one recent weekend, nine of 12 shootings in the city involved students from Marshall, including one who discharged a gun in his girlfriend's mouth.

Observers characterize the neighborhood as a place of distrust and fear, segregation, racism, and poverty. Students at a nearby school are bitter rivals of Marshall students, and the two groups often fight or threaten each other.

Major Program Features

Planning and Implementation

The goals of this project were (1) to reduce violent incidents on campus, (2) to intervene on behalf of high-risk students who were victims of violence or had a history of disruptive or violent behavior, (3) to increase attendance by reducing students' fear of violence at school, and (4) to develop a more cooperative spirit in the school that would empower students to solve their own problems and reduce the need for suspensions. Planners expected to reduce fighting through peer mediation and reverse the escalation of minor incidents by promoting conflict resolution. Planners also hoped to infuse all students and staff in the school with violence prevention and mediation skills.

Realizing that violence prevention was a pressing need at Marshall, the manager of Marshall's school-based clinic applied for funding from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA BPHC) for the mental health/violence prevention component. After discussing the opportunity with the community health center's development staff, CEO, and chief operations officer to gain their support, the manager proposed a three-part project including (1) the violence-prevention curriculum delivered in classrooms, (2) peer mediation, and (3) increased mental health counseling. A counselor at the clinic negotiated for space in which to counsel students.

The health center received funding for the project at the same time the school was splitting into sub-schools. Although the clinic director/program manager had the lead role in planning, she tried to build a broad base of investment by discussing her ideas with many stakeholders. In particular, she explained the mental health/peer mediation project to each principal to encourage their buy-in and to arrange for implementation of the violence prevention curriculum in classrooms.

The greatest supporters of the plan were the school-based clinic and a small group of teachers who acted as a sounding board for the program manager. In retrospect, the manager says she might have benefitted from more involvement in planning by the regional superintendent of schools and the city school system to generate more high-level support from the schools. Although the principals gave initial support, two were new to the school and had a lot to attend to—not the least of which was a state grant for reorganizing the schools to prevent the state from taking over the struggling institution. Although the violence prevention project was included in the school improvement plan, the principals' attention was consumed by the restructuring grant.

The program manager kept the principals informed at every juncture of implementation, sent information to faculty members, arranged presentations at faculty meetings by the violence prevention teachers and trainers, convened a school-wide assembly at each sub-school to introduce the program to students and faculty, and provided faculty training sessions to discuss

violence prevention and teach educators how to select students to participate in peer mediation.

Teachers nominated students as peer mediators, and the principal selected several teachers to participate in student training sessions during the teachers' planning periods. Despite this involvement, in retrospect the program manager says she would seek more active involvement from the school: "I wouldn't do it all on my own. I would be more of a facilitator, and get them to do more on their end so there was more buy-in."

Unlike other sites that received the violence prevention grant, THAT Place included an evaluator from the beginning of the planning and implementation process. The evaluator, who had been a back-up physician at the school-based health clinic, was often present at meetings when the peer mediation trainers provided feedback on implementation issues.

Program Design

Since 1988, THAT Place has provided students with a range of primary care services including complete physical check-ups, reproductive health assessments, hearing and vision screening, laboratory tests, weight control, health topic discussion groups, sick care, and mental health services. The violence-prevention project used three strategies to extend the clinic's basic health services. First, all Marshall students receive classroom instruction in a violence prevention curriculum. Second, a peer mediation program trains students in conflict resolution and provides a forum to practice these skills. Third, students have access to mental health services including individual and group counseling. All students are eligible for these services and are encouraged to participate.

The program manager tried to choose violence prevention components that would (1) ultimately lead to school ownership, (2) be inexpensive to sustain, (3) be self-perpetuating, and (4) relate to instructional or educational strategies such as cooperative learning. Implementers have found that neither component alone is sufficient to reach the students who need help.

The violence-prevention curriculum. This classroom-based component targets all sixth graders and incoming seventh graders at the two sub-schools and, at the principal's request, all students at the separate school on campus for students with emotional and behavioral problems. The conflict resolution facilitator who implements the curriculum visits four classrooms at each school twice a week for 10 weeks, one sub-school at a time. Following a curriculum designed by Deborah Prothrow-Stith, M.D. (and disseminated nationally by Education Development Center, Inc.), students use role-playing to learn conflict resolution and to practice and internalize violence prevention skills. Activities include reading poetry, viewing videos, and listening to presenters. Student preferences help shape the program; for example, the original curriculum, developed for high school students, does not introduce role playing until late in the sessions. The facilitator found that middle-school students engaged in the concepts more quickly if she introduced role playing at the beginning. She also found that documentaries and straight lecturing do not hold students' interest. "Videos should have plots," she advised.

Planners chose the classroom-based violence prevention curriculum in the hopes that it would establish a permanent anti-violence component. "Since this was not an ongoing grant, I wanted to set up something that in subsequent years could be targeted to incoming students, so everyone would get exposed to the materials," the health program manager said. Although in 1995 the curriculum was delivered in science classes, during 1994 it was conducted in language arts classes. The facilitator prefers to work in language arts classes because it is easier to integrate the concepts with writing assignments and real-life examples.

Peer mediation. Selected faculty receive a full day of mediation training at the school or off site, provided during the first year by the American Friends Service Committee (AFSC) and currently by the Citizenship Law and Education Program for Schools in Maryland (CLEPSM). The training that faculty receive duplicates the training student mediators will receive but also emphasizes ways of supervising student mediators and modeling conflict resolution behavior for students. Faculty who attend the first day of training also have a chance to air any concerns they have about the peer mediation training.

Before convening the faculty training sessions, the CLEPSM trainers survey parents, teachers, and students to learn their concerns and to tailor the training to local needs. At Marshall, a pre-training teacher survey revealed that teachers were primarily concerned about (1) students using mediation as an excuse to miss class; (2) teachers using mediation as a "quick fix" that fails to address deeper problems; (3) giving up control over students in order to allow them to solve their own conflicts; and (4) introducing a process that creates more work for teachers.

Trained faculty identify potential student mediators within each school, making sure that student mediators reflect the racial and gender mix of the entire school. During the first year, staff trained 48 students during five half-day sessions; 28 students passed a test at the end of training and became mediators.

Student mediators learn the theory and concepts undergirding peer mediation and participate in exercises and games that help them understand the nature of conflict. Students act out scenarios and practice analyzing their emotional reactions and responses. Team-building games also help trainees forge a sense of comraderie and understand group dynamics. An additional goal of the training sessions is to improve students' social skills, enabling them to predict, avoid, and diffuse potentially dangerous situations.

Trained peer mediators conduct mediations in special rooms in the schools or in classrooms. With the exception of emergency situations, mediations are typically scheduled during the free period of a trained teacher coordinator, who must be present for each mediation but does not actively participate.

Mental health counseling. These services include individual and group counseling. Two part-time psychologists visit the school-based clinic during five half-days a week to meet with students referred by teachers, peers, and the clinic's entry assessment. Group topics include self-esteem, sexuality, peer pressure, and family issues.

The counseling initially included anger management groups, conducted by a mental health liaison, that met for 45 minutes once a week over the course of six weeks. Students were referred to the program by teachers, vice principals, and counselors who noticed angry outbursts or disruptive behavior. The groups focused on helping students understand the triggers of emotional and physical anger and practicing non-violent behaviors to channel anger. Group leaders stressed the importance of confidentiality, self-esteem, and group cohesion. Students formulated group rules and received certificates and rewards for good attendance and participation. This component was canceled because of lack of funding for the mental health liaison, however. In addition, space for the anger management sessions was not consistently available; space within the health clinic was severely limited and required negotiation with other services, and counseling sessions were often interrupted. The frequent rescheduling was disruptive to troubled students, who need a sense of stability.

Implementation. Project leaders generated support by holding an assembly to introduce the new services and to encourage students to participate; when the first group of students passed the mediation training test, they received certificates, notebooks with mediation materials, and T-shirts with the mediation logo at a schoolwide assembly. The program continues to hold two assemblies every year—one to generate interest and answer questions about confidentiality and one to celebrate student mediators.

Despite some implementation problems (see below), planners still hope to see the peer mediation component and other violence prevention goals picked up by school staff. In addition, a local group of prison-based Jaycees has developed a second mediation/violence prevention project, called Project Choice. Through this venture, students visit the prison and prisoners provide counseling, mentoring, and advice about avoiding violence. Teachers and a conflict resolution facilitator, who works out of the school-based clinic, are identifying students to participate in this project as well as the one sponsored by the clinic.

Health care providers say the services have not yet met the counseling and anger management needs of many students because of limited staff, space, and coordination with the school. Sources said that adding more counselors and a separate space for counseling, and increasing support from school leaders, would improve the program.

Referrals. Students who are involved in the most serious violent incidents at school are referred to the school-based health center. Teachers trained for the peer mediation program select students to receive mediation training. Teachers also refer students for counseling. In addition, every student seeking health services at the school-based clinic responds to a list of questions designed to identify medical and mental health needs and risk behaviors. Based on these responses, health staff refer some students to counseling.

Parental consent. The school-based clinic requires a parent signature on a consent form, valid for three years, that permits mental health as well as medical services. The clinic sends the form to families at the beginning of the school year and gives additional copies to unsigned students who come to the clinic seeking services.

Organizational/Management Structure

The clinic's program manager has oversight over all clinic staff, including the conflict resolution facilitator. The program manager grants her staff a great deal of autonomy, and staff members are increasingly involved in strategic planning as the clinic begins to implement Total Quality Management techniques. When the violence prevention project first started, the program manager convened weekly management meetings to discuss implementation issues, barriers, and solutions; now, supervision is more informal, although the program manager said weekly meetings would still be desirable if time permitted. The CLEPSM peer mediation trainer also has full autonomy but discusses his activities regularly with the program manager on an informal basis.

Ideally, peer mediation trainers are expected to train teachers and students to take over the program, with the trainer available as a resource. The project at Marshall has not yet reached this stage, however. The teacher-coordinators also are expected to be responsible for the mediation program's day-to-day operations. This can take as much as one class period a day, however. In emergency situations, such as a fight, all available mediators and coordinators are expected to respond to a summons over the public address system.

Staff supervision for violence prevention activities is minimal at this site. The program manager initially supervised services, but she is often busy with other responsibilities. Faculty can call the peer mediation trainer with questions at any time, but he does not formally supervise them other than offering training and answering

questions. The trainer visits the school to give presentations at least twice a year, and drops in informally to solicit student input on services, support teachers, and encourage student participation. Because teachers call the peer mediation trainer with more questions than he has time to respond to, he believes that Marshall should have a full-time peer mediator or part-time peer mediation counselor and a teacher who is responsible for coordinating other faculty members and outside resources. The informal supervision process allows health and school staff to develop their own creative approaches, but it also means that the program manager—who is ultimately responsible for resolving problems—may not hear about issues until they escalate.

Staffing

The staff includes a classroom curriculum facilitator, two part-time psychologists, a part-time evaluator, and a part-time mediation trainer who works for an outside agency. Staff member's backgrounds are varied. The conflict resolution facilitator was a teacher for several years; the first peer mediation trainer had provided similar services in other schools and teaches at the college level; the original counselor had worked in psychodrama at a psychiatric hospital and had a great deal of experience in group sessions; and the program manager is an experienced health administrator and pediatric nurse practitioner.

Lack of teacher time and high turnover among school staff has hindered the project's efforts to coordinate services. For example, the original mediation trainer had hoped to involve at least two teacher-coordinators from each school at a time, but rarely attracted more than two (total). In one sub-school, all the teachers who were trained in peer mediation have now left; in another sub-school, the teacher assigned to be in charge of peer mediation taught five classes a day and did not have time to devote to mediation. Even without turnover, observers say that the trained mediation staff is stretched too thin to adequately serve the high number of students needing services.

Integration and Coordination

Two of the project's three components—the peer mediation program and the violence prevention curriculum—were designed to be integrated into classroom activities. Although one of the sub-schools successfully began implementation by giving a teacher one period a day to devote to peer mediation, the activities encountered stiff resistance from some school staff. Teachers felt that the first person hired to train them in the peer mediation project had a condescending approach and did not engage their interest. Although teachers approved of the content of the training, the focus was on reading information and "doing it by rote" rather than on finding interactive ways to incorporate new techniques. The trainer, meanwhile, felt that the school did not support her efforts by providing adequate space and teacher release time for training or weekly coordination meetings. She also found the school environment uncomfortably chaotic and noisy.

As teachers grew disenchanted with the project, they complained first to the principals and later to the health clinic manager. The program manager met with teachers and principals to address teachers' concerns. During the summer of 1994, the AFSC trainer was replaced with a trainer from the Citizenship Law-Related Education Program for the Schools of Maryland, who appears to have strong support from school staff and administrators.

The key to overcoming coordination issues has been one-on-one communication between the program manager and the principals. Both stakeholders must continually reiterate that they are both on the same side—working in the interest of improving children's conditions—and that coordination and negotiation are important. For example,

the principal of the special education sub-school meets frequently with the classroom conflict resolution teacher to go over her schedule and curriculum. The principal feels strongly that it is his responsibility to arrange the delivery of conflict resolution services for all of his students, and to keep informed about the content of any services provided by an outside educator.

Despite the setbacks, principals at Marshall say they see the violence prevention project as a "prominent part" of their schools' school improvement plans that is compatible with the city-mandated plan for dealing with crises in schools and with state goals of (1) increasing attendance, (2) improving school climate, (3) supporting student achievement, and (3) reducing the number of students designated for special education services. A principal also suggested that conflict resolution activities support the instructional strategies that she encourages her faculty to use, such as cooperative learning techniques.

School counselors at two sub-schools say they appreciate the peer mediation component because they no longer have to intervene with every crisis; now, some students can solve some of their own problems. One counselor is using knowledge she gained by participating in peer mediation training to develop a special unit on conflict mediation that homeroom teachers will present in classrooms along with other "advisory" topics. Another school counselor serves as the lead teacher-coordinator for peer mediation at her sub-school.

Parent, Family, and Community Involvement

Most parents are not actively involved in school activities, perhaps because children are bused to the school from across a wide enrollment area. The clinic provides referrals for family counseling and family sessions at the clinic when needed, but few parents follow up on these services and counselors have little time to follow up on families' circumstances. The reluctance of many families to visit counselors, requirements that parents visiting the school sign in and obtain passes, and the distance between the school and most students' homes further reduce parent involvement.

However, on an informal basis parents appear to benefit from the peer mediation training that school staff have received. A school counselor who received intensive training said that when asked to intervene with two families in an ongoing feud, she found herself giving them the ground rules for mediation, teaching them to verbalize their feelings, and building their listening skills. Later, when one of the mothers returned with her troubled daughter in tow, the counselor was encouraged to hear the mother advising her daughter to use the same techniques in expressing her anger.

Cultural Responsiveness

Although sources were reluctant to dwell on this point, it appears that the first peer mediation trainer—a white female—was perceived by teachers and students as less culturally sensitive than her replacement, an African American male. Project leaders responded to the schools' dissatisfaction by replacing the trainer. School and health sources credit the second trainer with better understanding the cultural issues and backgrounds of students in this largely low-income, African American community.

Funding and Reimbursement

THAT Place's primary operating expense is staff salaries and benefits (roughly $198,700 in 1996 for seven staff members). Facility costs—including building and equipment maintenance, telephone, answering service, and supplies—are approximately $6,500 a year. Other miscellaneous expenses (e.g., malpractice insurance, consulting services, administrative costs, travel, meeting attendance, and printing costs) amount to $44,500 a year. Approximately 18 percent of the clinic's revenue comes from medical

assistance reimbursements, 11 percent from fee-for-service payments by clients, and less than 1 percent from off-site payments. The clinic also obtains support from United Way, a city children and youth grant, and a private local foundation; Baltimore Medical System contributes approximately $100,000 a year.

Implementation Issues, Barriers, and Solutions

The myriad school changes that occurred in conjunction with the violence prevention project diluted school investment in the project. "I think we made the right move, but given the amount of change going on simultaneously... the program didn't get as much support as we would like," a planner observed. "[The school] had to run with this, but there were just too many things to run with." In addition, teachers faced with a state-mandated quota of contact hours with students found it difficult to leave their classrooms for mediation training.

Another factor that affected teacher participation in peer mediation was an unexpected reduction in enrollment at one of the sub-schools in 1995-96. Because school funding in Baltimore follows the student, when the enrollment fell by 100 students the school had to reduce the number of teachers—a move that hurt morale and further reduced the availability of faculty participants.

It takes time to develop trust and understanding among collaborators. At first, educators and health professionals at Thurgood Marshall lacked trust because they hadn't had a chance to develop working relationships—and because the school had to adapt to too many changes with too little staff. Neither the clinic program manager, the principals, nor the teachers had adequate time and to build new relationships and oversee the collaboration. Over time and through continued efforts to talk about their conflicts—especially face to face—the stakeholders are developing better relationships.

Some school structures, while supportive of education, do not encourage collaborative mental health efforts. The physical separation of the sub-schools may have impeded implementation throughout the entire campus. A counselor observed that much of the violence originates outside the school or on buses—not within a specific school—so it may affect students at several sub-schools. Peer mediation and violence prevention training should therefore be implemented in all sub-schools, preferably with some system of joint authority and oversight.

Program components may need to be modified to accommodate students with special needs. Many students enrolled in the special education sub-school are not able to complete all of the written and oral exercises required by the classroom or peer mediation components of the program. To meet their needs, these students receive more individual adult attention and learning activities that match their diverse academic levels, which range from kindergarten to grade 12. Social workers and other school staff also take an active role to ensure that violence prevention programming is consistent with students' behavior modification or therapy activities.

Accountability and Self-Assessment

The project evaluator hoped to collect both quantitative and anecdotal data for an overall evaluation of the program but found it difficult to identify quantitative measures of success. Initially, planners wanted to compare Marshall with a control school that had comparable disciplinary and violence incidents. But the school restructuring at Marshall had created a new administration, divided the school in half, and established new policies that reduced disciplinary suspensions. These changes made it impossible to compare circumstances before and after implementation of the violence prevention program or to compare Marshall with a control school. Instead, the evaluator relied on anecdotal data.

The evaluation included (1) questionnaires, submitted to teachers and counselors, designed to collect baseline data on physical violence and verbal abuse from and between students, including classroom disruptions; and (2) interviews and questionnaires to assess the program's impact on students. A first round of questionnaires, asking teachers to rate violence in the school and to identify the number of violent incidents they had witnessed in the school, was distributed in early 1994 before the program was implemented. (When teachers failed to respond to the questionnaire, the clinic sponsored a catered luncheon and used the questionnaire as a meal ticket. Ninety-eight percent of teachers responded.) The evaluator distributed a second questionnaire in spring 1995, one year after implementation. Teachers were asked to rate the level of violence in the school, identify the program's impacts, and suggest changes that could improve the program. Although final results have not been tabulated, the evaluator says that most teachers seem to indicate that program made a difference in the level of school violence.

The questionnaires also asked teachers how they thought student behavior had or had not changed. As the evaluator explained:

> *We thought about what we wanted to see changing in the school, incidents like students hitting each other or teachers, or verbal abuse, yelling, fighting. We asked teachers if those behaviors had changed. And then we asked students if they thought their own behavior and that of their peers had changed.*

Interviews and questionnaires targeting student leaders—some of whom participated in peer mediation and some of whom had only the classroom violence-prevention curriculum—indicated that most students felt a personal impact. Students described developing the ability to walk away from taunting and to resolve conflicts with their peers. These impacts were especially prevalent among students who participated in peer mediation training, who said the training definitely helped them in their own lives.

The evaluator is now analyzing the second round of questionnaires and comparing them with the first set of teacher responses. The evaluator also plans to conduct more extensive interviews with a broader tier of students, including those who are frequently in trouble. She also hopes to elicit input from the special education school and from a broader array of school staff, including school police officers.

The evaluator would like to establish quantitative measures of impact. Because the school administration has remained constant throughout implementation of the violence-prevention program, she may compare suspensions or police reports filed before and after implementation (assuming policies and practices have been consistent). However, evaluators have had trouble gaining access to school records, such as attendance records for children who receive mental health counseling. Although the sub-schools collect some data (e.g., regarding the number of disciplinary actions, mediations, and results of each mediation; school suspensions; dropout rates), the school-based clinic does not have access to this information. One principal said her school keeps the information only in students' individual files and does not compile aggregate data.

Despite difficulties, observers say evaluation is very important for violence prevention programs because it helps identify which of many efforts to help children are most beneficial—and reveals false assumptions. For example, evaluators who had assumed that adolescents would not have the patience and comprehension to answer a long, involved questionnaire found that students actually enjoyed the process and understood the questions.

Evidence of Success

Mental health counseling. Health providers say this component has worked well; more students are receiving services, including some students who do not use the school-based clinic. Anecdotal evidence shows that some students who previously acted out and skipped class improved their attendance; a child who often fought learned to use breathing exercises to control his anger.

Violence-prevention curriculum. All students were exposed to this component through classroom sessions. In interviews with the evaluator, most students reported a positive experience and impact; they felt they were handling personal conflicts better and that school violence had decreased or remained the same since implementation.

Peer mediation. This component has had mixed success across sub-schools. At one sub-school, 30 students and four teachers received intensive training in peer mediation in 1994-95. A school counselor who received training and observed about 10 mediations said the process gave the students maturity, a sense of responsibility, and something to look forward to. At another sub-school, 12 students and two teachers were trained and the teacher-coordinator is preparing to train additional students and staff. At the sub-school for behaviorally and emotionally disturbed students, 12 students went through a modified training program with the assistance of an interested teacher who is trained in crisis intervention.

In interviews with teacher-coordinators, the evaluator found that the teacher in one sub-school had been very impressed with the peer mediation program but felt that the principal did not support it sufficiently by building awareness of the program among other staff and by allowing enough time for supervision and coordination. (Teachers at both schools are expected to use their planning periods for the project; paid release time is not available.) The teacher-coordinator at this school has since transferred to a different school; the remaining teachers who participated in the program at this school said they liked it.

At another sub-school, many of the students who received mediation training transferred out or withdrew. The remaining students did well at first, but when they progressed to the section of the school reserved for older students they were intimidated and lost confidence, a school counselor said.

Peer mediators in the school for emotionally and behaviorally disturbed students participate in modified mediations in which they sit in on post-crisis interviews with social workers and other students. The school's principal refers to peer mediation as "a natural step in the school's clinical work with the children" because it embodies the same values of communication, cooperation, and self-reflection used in other therapy approaches at the school. The principal has noticed a decrease in violent incidents since the introduction of the program, as well as a heightened capacity among some students to understand and learn from their own violent behavior.

School environment. Students are eager to participate in the mediation program, and attendance has improved among student mediators because they must attend school in order to participate. Student mediators apparently enjoy a special status on campus because the program has mystique: All students know that mediators go to special meetings, but only those who participate in mediation know what happens there because the interaction is strictly confidential. Conflict resolution training is especially helpful for students with learning disabilities or emotional disturbance because it enables them to develop important non-academic skills

in a safe environment, a teacher suggested. Mediation skills can give these students a sense of accomplishment, the respect of teachers and their peers, and the ability to contribute to the school in a positive way.

Tools for assessing impact. In addition to the formal evaluation, the peer mediation trainer said he recognizes success when students realize they have a mechanism for resolving conflicts, the level of aggression is reduced, and members of the school community report that the general environment has improved. Over time, the trainer expects the number of mediators to increase, along with students' desire to participate.

E.A. Hawse Health Center, East Hardy High School, and East Hardy Early/Middle School

Baker (Hardy County), West Virginia

- Services target domestic violence, drug and alcohol abuse, and other mental health needs in a rural, isolated community
- Project serves a range of ages from elementary through high school

Overview

A full-time mental health counselor enhances the ability of the school-based clinic to provide long-term, in-depth counseling and crisis intervention to high school and middle school students facing substance abuse, domestic violence, lack of adult supervision, and other problems. Counseling for elementary and middle-school students focuses on healthy behaviors and crisis prevention. A 24-hour crisis hotline provides referrals for emergency health and mental health services.

Number of students served: 750 students enrolled; approximately 560 receive counseling (3,200 patient encounters per year)
Grades served: 1-12
Racial/ethnic breakdown: 99% Anglo, 1% African American
Children living in poverty: 70% of elementary/middle-school students and 33% of high-school students qualify for free or reduced-price lunch
Major sources of funding: Violence prevention grant from the Health Resources and Services Administration's Bureau of Primary Health Care

Community Context

East Hardy County is a rural, isolated area of approximately 3,200 residents nestled on the western side of the Appalachian Mountains. A Time Magazine review of the state of children's health in 1993 cited West Virginia for the highest rates of children who smoke and motor vehicle accidents. A similar study in Baker, West Virginia recognized behavioral problems, suicide attempts, smoking, and other unhealthy behaviors as significant health concerns for students.

To find employment, most residents drive long distances to poultry processing plants 20 miles to the west or across the mountains to service jobs in Virginia. These parents are rarely home (or, if they work the factories' night shift, are sleeping when their children are home) and therefore provide little supervision or support. These parents also find it hard to take their children to medical appointments during work hours.

Baker residents can receive health services from one private psychologist, a mental health agency, one private counselor, and a hospital located 45 minutes away. However, the mountain that separates east and west Hardy counties takes 25 minutes to cross—and local prejudice runs strong against the other side of the mountain, limiting access to these services.

School Context

East Hardy Early/Middle School, which serves 500 students in prekindergarten through eighth grade, is located next to East Hardy High School, which serves 250 students in grades 9-12. The E.A. Hawes Health Center operates a school-based clinic at the early/middle school that serves students from both schools. The clinic, established in 1993, provides primary and acute health care and mental health counseling.

Approximately 10 percent of students have recently moved to the area from outside the state. Although some simply come with parents seeking jobs and an affordable cost of living, others are transferred because of behavioral problems or because their families were not accepted by other communities. These students often have adjustment problems. In 1994-95, six of nine students who dropped out of East Hardy High School were students who had transferred from outside the community.

There were no counseling services in Hardy County schools until three years ago, and in 1993, six students at East Hardy High School attempted suicide. Now, a sole elementary school counselor splits her time between two schools in the 575-square-mile county but does not serve the high school. Her caseload is 1,200 students—four times the recommended number—and that does not include students in seventh and eighth grade. The county has only one school nurse, who must divide her time among four schools.

A state "safe schools" law that took effect in 1995 allows teachers to exclude students from class who are threatening, disruptive, disrespectful, or dangerous; it also calls for counseling as well as disciplinary action. This has dramatically increased the number of students involved in disciplinary actions and counseling.

Major Program Features

Planning Process

In the early 1990s, staff at E.A. Hawse Health Center, a community health center, began hearing from parents that it was difficult for them to obtain health care for their children. The health center's administrator sought advice from a physician in a nearby county who was already working with a school-based clinic and conducted a health risk assessment on two elementary schools to verify the need for increased access to health care. In 1992, the West Virginia Board of Education and the American Medical Association chose Hardy County as one of four pilot sites in the state to develop comprehensive school health initiatives. Hawse Health Center became the lead agency for the project (called Healthy Schools), which seeks to integrate health and health education into the schools (e.g., through health fairs and nutrition programs).

Planners of the school clinic held a public meeting in Moorefield, a town 20 miles away where the school district headquarters are located. About 100 residents showed up—an unusually good turnout for the rural area. Planners used the meeting to assure parents that the school-based clinic would not provide children with family planning or birth control services in the schools, although the health center does provide information on options and services available elsewhere. Planners held a second meeting in Baker to assess specific health needs. Planners then formed an advisory group that met monthly to oversee planning and implementation. Project initiators and key planners included the health center administrator and staff, the school health director, the county's school nurse, the coordinator of the Healthy Schools program, the county extension agent, some teachers, a principal, the local ministerial association, and the superintendent of schools.

Hawse then hired a clinic coordinator, who collaborated with a school health coordinator hired by the board of education. They adapted the clinic proposal developed by the neighboring county, incorporated recommendations by the board of education, and obtained approval and space from the principal. The school-based clinic opened at East Hardy Middle School in 1993. The planning process for the clinic—from the first health risk appraisal to implementation of services—took about 18 months. Planners worked together but took on different roles.

"My concern was instituting health care and counseling services in the school system," the health center administrator recalled:

> *Some of the educators and principals were more concerned about how to institute health in the curriculum. The extension service's concern was getting the program up and going—more of an overall picture. The ministerial association was concerned with making sure we were doing it morally. We all had our own expertise in different areas.*

Planners viewed the school-based clinic and the Healthy Schools initiative primarily as an opportunity to increase access to health care for children not receiving services. But once the clinic was established, teachers expressed a strong desire for mental health counseling to counteract prevalent substance abuse, peer pressure, neglect, and latchkey circumstances. An advisory committee established by the Healthy Schools initiative, which included health center staff, provided a forum for airing these concerns; a health risk assessment conducted by Hawse at two schools, which revealed suicide concerns among students, also supported the need for counseling services. The decision to apply for HRSA BPHC's violence-prevention funding to support a full-time mental health counselor grew from this realization.

"Everything flowed together," recalled the health center administrator: The school-based clinic was supplemented by Healthy Schools, which lead to the mental health/violence prevention component.

The school-based mental health/violence prevention counseling component began in May 1994. After principals and teachers requested counselors from the health center, the health center administrator talked individually with the superintendent of the board of education, who supported the idea. The Healthy Schools coordinator also provided input—for example, suggesting that the project offer long-term counseling as well as crisis intervention.

Planners did not have to build support for the violence-prevention project; there were no detractors and there was already strong support from the superintendent, the health center board, and the board of education. The health center administrator kept in touch with a regional guild of mental health professionals so outside providers wouldn't feel threatened. The guild lent its blessing for several reasons: the administrator sits on the guild's board and therefore has a close relationship with its director; the guild is located an hour away from Baker and had no members in the area; and the guild had prior unsuccessful experiences with the East Hardy school system. "The unique thing about planning for the counselor was the fact that everybody wanted it—there was no opposition," said the administrator:

> *We had the principals and educators involved in the hiring process. We tried to keep all the players involved: the principal of the high school, the assistant principal of the middle school, and the health staff were involved in interviewing counselors. We felt that they (schools) were going to be seeing the counselor more than we would, so they have to have a say.*

Principals confirmed that their involvement in hiring the counselor alleviated concerns about how much input the school would have and what the project would look like.

After selecting a counselor, project planners chose a starting date for the violence-prevention services. The administrator's assistant took the counselor to school faculty meetings to introduce him to teachers, and the elementary school principal distributed a flyer on the new service. "Word of mouth goes a long way in a small community," one source advised.

Program Design

Goals. The school-based health program's initial objectives were to (1) place a full-time counselor at the school-based health center at the schools for four hours a day throughout the school year; (2) support school health programming with resource materials for staff, lab tests, and health promotion/prevention materials for students; and (3) provide a 24-hour crisis hotline for all county students. According to the health center administrator, other informal goals included lowering substance abuse and alcohol and tobacco use among students; decreasing peer pressure; decreasing the teen pregnancy rate; and educating children about their health choices.

The project's initial goal was to "target/address behavioral problems by placing a full-time counselor at the school-based health center [and to] promote adolescent wellness with a comprehensive school health initiative in cooperation with Hardy County schools, [the] mental health guild, and other community organizations and agencies." Since implementation, this goal has expanded to include addressing specific mental health needs.

Services and activities. The counseling component was implemented simultaneously at the elementary/middle and high schools. The counselor is available four hours a day, five days a week at each school. The proximity of the schools makes the counseling very accessible to all students, but there are some differences for age groups. Services for children in third grade and below focus on short-term problem resolution, while older students receive more long-term and continual therapeutic counseling—at a minimum, every two weeks.

Most counseling occurs in individual sessions that address a range of emotional and behavioral problems, including drug, alcohol, and tobacco use; conflict resolution and violence prevention; and coping with stressful situations such as divorce or latchkey circumstances. Although the counselor has attempted group sessions, especially for children from divorced families, students have trouble building enough trust in group settings to allow meaningful discussions. Most students receive counseling on the same day that their need is identified; no student must wait longer than three days. At the request of teachers, the mental health counselor also delivers information on self-esteem, goal setting, and personal relationships to eight "advisory" classes at the middle school for one week, three times a year.

The counselor meets with students in the schools or at the health center. Local referrals for emergency services are provided at all times by a 24-hour national hotline service to which the clinic subscribes.

Service protocols. The health center's director of school health, in collaboration with the mental health counselor, is drafting protocols for school-based mental health services. The protocol will include such topics as school staff consultations, confidentiality limits, parental contact, academic and treatment referrals, specific treatment areas, ethical and legal issues, the reporting of child abuse, and coordination with school support services. Administrators plan to use the protocol guide, which also includes encounter and referral forms, will be used to orient new staff.

Parental consent and referrals. All students are eligible for services unless their parents request that they not be seen. The counselor sends parents a one-time, blanket consent form to sign that combines consent for school-based medical and mental health services. Parents must contact the counselor if they do not want their children to receive counseling. A few parents resist the services because they are uncomfortable having private problems discussed outside the home or for religious reasons.

The counselor sees about 75 percent of all middle- and high-school students during the course of the school year, either individually or in group sessions. Most students are referred by teachers or themselves; school administrators, peers, and parents also may generate referrals. Most referrals are by word of mouth, although the counselor provides teachers with referral forms to prompt their participation.

A core group of five or six female high school teachers seem to make most of the referrals. The school nurse and some teachers said they refer students to both the mental health counselor and the school counselor based on availability, student needs, or efforts to avoid turf issues. "I try to go through the school system as much as possible, so [the school counselor] isn't left in the dark," the school nurse explained. In the middle school, many boys seem to prefer referrals to the mental health counselor, who is male, because the school counselor is female.

Student needs. Most common counseling needs are for students from divorced families, students with several (often two or three) stepfathers, and students living in alcoholic families. Drugs and alcohol are a particular problem for high school students; of the 250 students at the high school, the counselor estimates that 10 percent are actively using drugs or alcohol, between 20 percent and 30 percent are experimenting, and 8 percent deal with drug abuse verging on dependence. In addition to alcohol and marijuana, students lace marijuana with formaldehyde or model rocket fuel instead of PCP.

Confidentiality. All school personnel who interact with Hawse Health Center sign a confidentiality agreement that (1) designates as confidential all "information on patients' medical records, telephone conversations, family history, diseases or illnesses"; (2) prohibits the discussion of health "practices, policies, types of cases, or internal problems"; and (3) makes it clear that "any attempt to gather information regarding a patient...for your own personal information or to inform someone of such information will result in disciplinary action." However, the school nurse has limited access to certain information about patient diagnoses and treatment on a need-to-know basis—for example, if the clinic's nurse practitioner is not on site and the school nurse must know whether a sick student is taking medication or has already seen the nurse practitioner. The school nurse does not seek information or receive on students' mental health care.

The mental health counselor's confidentiality constraints, which are stricter than those of school staff, can cause misperceptions among teachers. Some teachers view the counselor as "secretive" and not as "visible" or "open" as the school counselor because he guards information about students. "He sure doesn't betray any confidences," complained one teacher.

Patterns in service use. Most students who receive mental health counseling are from single-parent, divorced, or blended families and have trouble getting along with their parents, step-parents, and/or step-siblings. The counselor meets with these students at least once or twice a week for about three months, and then less frequently as needed. Approximately equal numbers of male and female students receive counseling.

Organizational/Management Structure

The mental health counselor conducts the violence-prevention services with minimal assistance and a great deal of autonomy. The community health center introduced the violence prevention counselor to school staff and accompanied him to his first faculty meetings; now, the counselor meets informally several times a week with his supervisor (the health center's director of school health programs) to discuss administrative matters and some cases on a generic level. The counselor also submits to the director of school health programs a monthly report identifying the

number and type of mental health encounters and the names, ages, and risk factors of the students involved. The director of school health provides administrative oversight rather than clinical supervision, and the counselor says he sometimes would like to confer with a psychiatrist or experienced clinician before giving treatment.

The counselor views himself as having to please three bosses: the health center and the two principals who allow him to work in their schools. He is aware of having to conform to their wishes as well as meeting the needs of students, but has not encountered conflicts in this arrangement.

Staffing

Staffing at this site is minimal. A nurse practitioner operates the school-based clinic and a program director based at the health center provides administrative oversight. The violence-prevention/counseling staff consists of one full-time certified addiction counselor, who travels between the schools and also conducts adult therapy sessions in the evening for parents who cannot meet during work hours. Because of the great need for services, several sources suggested that the project would benefit from having two full-time counselors, divided between the two schools. An attempt to add a second counselor who provided services at an elementary school and high school in Moorefield, 40 minutes away, failed after six months because of limited funding and because the second counselor was not accepted by the schools.

A principal also suggested that the project would benefit from having a full-time social worker who could help families connect with additional services and counseling. Although the project proposal called for a social worker, none was hired because of funding constraints.

The health center provides some professional development by paying for the counselor to attend annual state conferences so he can keep his professional credentials current.

The counselor's role has evolved over time. First, he concentrated on meeting every teacher individually and attended student-faculty senate meetings to ask for referrals. Next, he spent time observing and talking to teachers to figure out "who cares, who doesn't care; who's rigid, who's flexible; who respects whom." In the beginning, the counselor focused on treating students with disciplinary problems. He scanned the school's attendance records and met with every child who missed three days in a month to find out why they were missing school. With female students, he matched their absences against somatic complaints—and often identified cases of sexual abuse. Next, the counselor focused on increasing referrals from teachers. He hand-delivered referral forms, asking for their help. Then he contacted all teachers who didn't respond to find out why they weren't using the forms.

Integration and Coordination

The counselor, health center staff, and school staff and leaders agree that the school clinic, the counseling project, and the schools work well together and are mutually supportive. Some teachers invite the counselor to talk to classes about specific subjects, such as "feelings and emotions and how to deal with them." Teachers use the counselor as a resource for informal advice on how a teacher can counsel a student. The counselor also presents group sessions on self-esteem at school health fairs sponsored by the Healthy Schools initiative and consults with the school nurse on problems such as a student's poor hygiene. Cooperative arrangements are negotiated through personal contact between the clinic and counseling staff and school leaders. For example, although the school-based clinic owns its own phone, it uses a phone line owned by the school; the school lets health staff use its copying machine.

According to a principal, one of the most important roles that schools have in facilitating mental health care is providing a "captive audience" for counseling services. If mental health care was not associated with the school, this principal said his students would not receive help until they were in the judicial or social services systems. The school views the counseling project as an important mechanism for earlier intervention.

The violence prevention counselor talks every day with two principals, a vice principal, and other school staff to discuss disciplinary actions, specific student needs and behaviors, and factors that could affect treatment, and to ask administrators or teachers to keep an eye out for telltale signs of distress.

Communication and flexibility are essential to good coordination, many sources agreed. Being flexible "makes other people more a part of the project—they're buying into it," the health center administrator explained. "Our goal is to provide the service; it would be [pointless] to provide a service if you've torn [relationships] apart before you get to providing the services."

The isolated, rural nature of Baker also provides a basis for strong communication. As the administrator explained,

> *Living in this rural area, I'm on the [mental health guild] board, they know me and I know them, and we have other meetings we go to together. I've known the principal at the high school for 30 years, and my daughter went there—they know me as a parent and as a professional. The principal at the elementary school is also my pastor. Living in a rural area does have some advantages when it comes to working with people—the base [of communication] is already built."*

The clear delineation of roles among the mental health counselor, the school nurse, and the school counselor also facilitate coordination, diminish turf barriers, and make the division of responsibilities evident. Health and school staff agreed that the school nurse concentrates on medical health needs; the clinic's mental health counselor, who has the greatest control over his schedule and has experience in serious drug abuse treatment, serves most long-term counseling needs and treats hard-core violence cases that require a "more confrontational" approach; the early/middle-school counselor focuses on students below sixth grade; and the high school counselor, who has an extensive background in social services, specializes in abuse and neglect cases.

Parent, Family, and Community Involvement

The counselor interacts with approximately 5-8 parents every week, usually by phone, to advise them about their children's needs, assignments or requirements, or medications. "Sometimes I ask carefully what parents' punishments are going to be for kids getting in trouble, or I suggest [that] parents organize punishments to focus on education more and less on disciplinary action," the counselor said.

The counselor conducts home visits infrequently—perhaps once every month or two—because of the vast distances between homes. "It could take me up to an hour to get to somebody's house," he explained. "Lots of kids are on the bus over an hour just to get to school.... They want to come to school because this is their only social interaction."

Parents and community members participate on the Healthy Schools advisory committee. In addition, health center staff are proactive in informing parents and community members of the counseling services. Before the counselor arrived, clinic staff sent information on him and his new services to local newspapers and included notices in the health center's newsletter.

Funding and Reimbursement

The project's budget comes primarily from the HRSA BPHC violence-prevention grant; the remainder is absorbed by the community health center. The major expense is salaries for the full-time counselor and providers at the school-based clinic who provide fringe mental health services, make referrals to the full-time counselor or to social services, and confer with the counselor. The grant also pays for the 24-hour I CARE hotline ($5,000) and equipment and supplies, including a laptop computer for case histories, office furniture, and a portable VCR for classroom viewing of educational videotapes. The schools contributed office space and a telephone, but not a separate telephone line.

The average cost per mental health encounter is $23.50. However, state law prohibits the clinic from charging fees for mental health services. Parents and families who are referred to the community health center for counseling pay sliding fees (e.g., $40-80 an hour for family therapy; $35-70 an hour for individual therapy). The collection rate is approximately 25 percent.

Health center administrators are extremely concerned about the long-term sustainability of the counseling component. Because the school-based mental health services do not generate revenue, health center administrators concede that they will be forced to seriously decrease these services if the center cannot obtain grant funding.

Implementation Issues, Barriers, and Solutions

Community resistance to key topics can limit program options. School-based health clinic staff are not allowed to discuss sexuality or sexual issues openly at the middle school, which limits their ability to identify some cases at an early stage or provide more preventive services.

Family apathy hinders some preventive services. Although the counselor advertised an Alateen group for one year, only one family showed interest in the service. Many people seem unwilling to seek help until they are in crisis.

The large service area and limited resources make the mental health counseling especially welcome in the schools and may facilitate coordination with educators. In a rural area where the elementary school counselor and the school nurse face awesome caseloads, school staff have a clear incentive to work with the mental health provider. "He'd be the first one I would call [for help] because I know the school counselor is divided throughout the county," the Healthy Schools coordinator said.

Accountability and Self-Assessment

The mental health counselor gives a monthly report of encounters to his administrative supervisor at the health clinic. The report assigns each encounter a coded risk factor (e.g., family problems or drug abuse) along with the student's name, age, gender, and grade level. The health administrator uses the reports for grant planning and incorporates the data into speeches she gives at violence prevention conferences to increase public awareness of the project. Administrators also hope to use the data to estimate the revenue potential of services.

The school district relies on front-line supervisors at the health center to assess the mental health services, but the superintendent notes that accountability is "a tough issue":

> *It's hard to know what are realistic expectations. The kids [the counselor] is treating, he's seeing because they're the hard cases; you're not going to solve all these problems.*

The district's criteria for judging success include changes in the behavior and lives of students, as observed by teachers and principals. The school counselor bases the mental health counselor's success on whether students like him and teachers respect his opinion.

Evidence of Success

Although quantitative evidence of success is scarce, anecdotal evidence shows that this project has successfully intervened in some volatile situations and has good coordination with most school staff, acceptance from many students, and respect from educators both inside and outside the school:

- Teachers and school administrators say the mental health counselor's intervention has enabled depressed or chronically truant students to remain in school, reduced classroom disturbances, and reduced the stress placed on teachers by violent or disruptive students

- A county school-health coordinator who substitute-teaches at the high school has noticed that the counselor meets regularly with the director of the education for high-risk students to discuss their needs; she sees this as a sign of good rapport with school staff.

- The county school-health coordinator observes that high-risk students feel more comfortable just knowing that the mental health counselor is on-site every day, and often will ask to go speak with him.

- A teacher reports calling the mental health counselor to her classroom to "disarm" a violent student who, while not carrying a weapon, was throwing things, hitting, and yelling. "Because [the counselor] was in the building, I was able to avoid a very unpleasant situation," she said.

- Educators in schools located 50 miles away from East Hardy have heard about the counselor's successes and have asked if they can send a violent, disruptive 14-year-old boy whom they are unable to help to the counselor working in Baker. "To have people calling him for help kind of makes me feel good," the school health director noted.

Clinic staff expect the long-term impact of the services to include better conflict resolution skills, reduced drug and alcohol experimentation, decreased teen pregnancies, and improved family relationships as students increase their self-esteem; learn to relax, ask for help, and learn from their mistakes; and distance themselves from the chaos in their lives. The length of exposure to counseling will increase the project's impact because it increases credibility, trust, and rapport, sources said.

The principals and school superintendent value the counseling project as a necessary service the cash-strapped school district is unable to provide on its own, especially after four years of running a deficit. "In the past, I might not have known what to do with a part-time counselor," said one principal. "Now, I could use a full-time counselor."

The superintendent also believes that counseling services improve students' readiness to learn. "Obviously, kids have got to be ready to learn if we're going to teach them anything. If mom and dad fought all night, or if dad just left, or if mom has a new boyfriend, or if the landlord just came and said they have to get out of the house because they owe rent, it's not a good environment for learning," the superintendent said.

Northeast Valley Health Corporation and San Fernando High School

San Fernando, California

- Expanded mental health services have dramatically increased the number of students receiving counseling and reduced the waiting time for services, the stigma attached to receiving mental health care, and the level of campus violence.
- Special services target Latino gang members, victims of gang violence, students dealing with acculturation issues, and homosexual students.
- Mental health interns supplement the professional counseling staff, providing training opportunities for new health care providers and adequate, affordable staffing to meet the needs of a large student population.

Overview

Mental health professionals and interns provide individual and group counseling; case management; mental health outreach through teachers and in classrooms; and in-service teacher training on the mental health needs of students.

Number of students served: The high school has approximately 3,100 students. The school-based clinic received more than 3,300 mental health visits in 1994-95 (55% of all health clinic visits). Approximately 75% of students use the services, although 90% have filed consent forms.
Grades served: 10-12
Racial/ethnic breakdown: 97% Latino, 2.5% African American, .5% Asian or Anglo
Poverty indicators: 52% of students receive free or reduced-price lunch; 14% live in families whose annual income is below the federal poverty line.
Major sources of funding: Violence prevention grant from the Health Resources and Services Administration's Bureau of Primary Health Care

Community and School Context

San Fernando High School is located in a high-poverty area of Los Angeles where most students have neither family doctors nor health insurance. Approximately 97 percent of the students are Latino, mostly of Mexican heritage; many suffer from acculturation problems due to recent immigration. Gang violence; teen pregnancy; and emotional, physical, and sexual abuse occur at high rates. In addition, the earthquake of 1994 dramatically increased the need for mental health services in the schools. The quake brought child abuse and grieving issues to the surface, project leaders say: "People suddenly felt vulnerable, and they flooded in" to the school-based clinic.

Four years ago, the school experienced a major gang-related crisis at least once a month. Local gang leaders arranged a truce in 1993 but physical violence continues to plague the community, which experienced its highest murder rate during the summer of 1995. Despite these circumstances, the county recently made significant cutbacks in mental health services. The Department of Mental Health was cut so severely that it almost closed in October 1995; the long-term impact is unknown. School-based clinic staff find it difficult to get the county's psychological emergency team or child abuse authorities to come to the school except in the most extreme situations.

Local resources include an infant care center for children from birth to age three whose parents attend the high school; a preschool program; a nearby high school for pregnant teens that focuses on healthy parenthood; a counseling program for pregnant teens; and a school dropout counselor for at-risk students. Although community agencies offer some counseling and the school-based clinic makes referrals, students rarely use these community services. Many families think they cannot afford services; there may be language barriers; and parents have trouble getting off work to keep appointments. The community agencies are not always user-friendly and have long waiting lists. And Latino families often attach a stigma to mental health problems and are reluctant to share private information with non-family members. The school-based clinic and counseling service are therefore essential to increasing access to health and mental health services.

Major Program Features

Planning Process

The San Fernando High School Teen Health Center opened in 1987 with funding from the Robert Wood Johnson Foundation. The director of school health services developed the violence prevention/mental health component in 1993 and obtained funding from the HRSA BPHC. The violence prevention project fit into the long-term goals of the community health center that operates the school-based clinic, which sought better ways of linking agencies and resources within schools. Before the added services, clinic staff identified students with mental health needs but lacked the staff and time to meet these needs. "We would grade [the cases'] severity from one through five," recalled the director of school health services for the health center. "We were seeing the fours and fives but not anyone else."

Key planners included the health center's director of school health; the school-based clinic's main mental health counselor, medical director, and nurse practitioner who worked closely with mental health staff; and mental health consultants provided by the school district. The health center's director of school health notified the school-clinic coordinator of the plans but did not consult the principal because she knew he approved of the additional services. "If I suspected he would object, I would have involved him," she said.

The health center's director of school health now says she should have involved the mental health interns who staff the services more centrally in planning. "The more input you have from the people actually providing mental health services the better, because they know what the needs are and what can and can't be done," she said. She also would have involved teachers from the school's mandated substance abuse/non-crisis mental health program to cultivate their investment and support.

The planners provided input individually to the health center's director of school health. First, the school health director asked the clinic's main mental health provider to list the ideal services for such a program. The director drafted a proposal and solicited administrative suggestions from the health center's medical director, who is also the director of adolescent medicine at the University of California-Los Angeles. The school health director then asked the school mental health consultants for their opinions. The consultants suggested offering stipends and other incentives to help attract student interns, especially ones who could speak Spanish and commit to a long period of service. The clinic's nurse practitioner commented on drafts of the proposal.

The planning period lasted only two weeks. "It wasn't like we had to sit around and dream up stuff to do with the money; it was more like 'How can we get the most out of it—not to make a big splash but to set up something that will still

exist when we run out of money,'" explained a key planner. Planning a violence-prevention project was much like planning any other service—a matter of identifying and prioritizing needs and deciding what could be done in the time given, with staff and space limitations.

Planners did not have to work to build support because there were no detractors. Although a few teachers resisted having students taken out of class for services, most teachers and the principal already believed that additional mental health services were needed. At the same time, the school did not want to draw attention to violence problems at the school. "The principal would like the community to look at it as a good, safe school—not as a war zone," acknowledged the school health director. "We've learned to be very tactful about that." It helped that the project needed no advertising because there was such demand for services and because students were already acclimated to using the health clinic.

To establish an infrastructure for the project, the school health director explained to the principal that the grant would provide extra staff, who would need space in which to work. The clinic asked the school district for space in which to provide counseling. The district provided a small portable bungalow (at a cost of $1,500 a year), which is used for small group and individual sessions. Counselors also use classrooms when available. Health center staff realize that the school is already operating over capacity; to make the most of the limited space, the director rearranged existing clinic staff to accommodate some new mental health staff.

Program Design

Goals and objectives. The project's objectives were to: (1) reduce student waiting time for services; (2) increase individual counseling from four to 16 hours a week to serve an additional 600 students; (3) implement a tracking system to assist case management; (4) increase the number of mental health group sessions from 12 to 17 to serve an additional 100 students, with topics including sexual abuse (in Spanish and English) and biculturation (in Spanish); (5) increase consultation time with school personnel to four hours a week; (6) provide classroom outreach on mental health services; (7) develop and implement training and education on mental health issues for school staff; and (8) increase staffing by mental health interns from 20 to 80 hours a week.

Activities and services. The mental health component includes individual counseling and an array of focus groups on attempted suicide, depression, sexual and non-sexual abuse, recent immigration, gang involvement, sexuality, victimization from violence, Post-Traumatic Stress Disorder, women's issues, and grief. Three groups address women's mental health issues (primarily having to do with girls being treated in disrespectful ways by Latino males); plans are underway to begin a group for gang members, run jointly with IMPACT (a federally funded student assistance program operated through the high school to combat students' substance abuse). The violence-prevention grant enabled the clinic to (1) increase service hours and expand services; (2) provide case management; (3) conduct mental health outreach to students through teachers and in classrooms; and (4) provide in-service training for faculty on the mental health needs of students. Services are provided from 7:30 a.m. to 4 p.m. year-round by mental health staff based at the school clinic and by mental health interns from local universities.

Mental health staff provide individual crisis intervention almost every day. Students may stay in individual counseling until they are comfortable with a group setting, and some students receive both group and individual counseling. The lead counselor encourages interns to follow up on selected students over time so they gain experience in case management. Some counselors also provide long-term family counseling.

Case management and tracking. Mental health staff use a computerized database to track students. The system includes students' names, chart numbers, dates of birth, consulting clinician(s), support group(s), coded assessment, referral date and contact, days of contact, type of contact, resolution of therapy, and class schedule. The lead counselor periodically generates group session lists and schedules from the database but does not yet use it daily because he views it as complicated (partly because he does not have easy access to a computer). The lead counselor updates the database at the beginning of the school year and the end of the first semester; mental health staff enter data each week following their supervision meeting. Ultimately, the counselor intends to use the tracking system to understand why some students aren't using the services and to identify patterns among students who receive services.

Mental health outreach. The most common form of outreach is individual advocacy by mental health staff on behalf of students who have disciplinary problems in school or have personal problems with teachers. Outreach usually consists of individual contact with teachers and school administrators, on an informal basis, aimed at increasing their awareness of mental health needs and counseling practices. Outreach designed to attract students to the counseling program or to contact many teachers simultaneously occurs only a few times a year and is conducted in collaboration with IMPACT.

Parental consent. All students who have submitted signed parental consent forms are eligible for school-based clinic services—approximately 90 percent of all students. Of these, about 65 percent are active clinic users. The consent form, which is good as long as the student is enrolled, covers both psychological and medical services. Parents who do not want their children to receive counseling or other services can indicate this in a special box on the form. Students receive the consent form when registering for school, in the hopes that parents will sign it immediately.

Although state law allows children above the age of 12 to seek counseling for family planning issues without parental consent, the school district requires parental consent for all services, so the school-based clinic also requires consent. By requiring consent, however, the clinic loses eligibility for state family planning funds.

Location. The mental health bungalow is located across campus from the health clinic, which is housed in the school health office. The bungalow is divided into several small cubicles, offices, and two group rooms furnished with comfortable couches, stuffed animals, and colorful posters. The project's health educator, the school psychologist, and the coordinator of the school's IMPACT program share the bungalow with counselors and mental health interns. To combat the lack of privacy in the cubicles, staff play loud music that prevents confidential sessions from being overheard. Although project staff say the mental health component needs more space to increase privacy and to give each intern storage space for patient records, the project lost a room in 1995-96 that was converted to classroom space.

Referrals. Teachers, school counselors, and school administrators generally support the mental health clinic and refer students for counseling. Student referrals have increased since the project began, and students often bring their friends into the clinic. Students are asked to fill out a brief mental health survey when they come to the school-based clinic for medical services, which alerts staff to possible mental health problems such as suicidal ideation, abuse, drug use, or sexuality issues. Questions are asked in a "Yes, no, not sure" format so the answers are informative but do not make students uncomfortable. By identifying students who might otherwise be noticed only after a crisis, the survey generates some referrals for preventive counseling.

Confidentiality. Early in the program, confidentiality concerns arose because providers constantly shuttled patients' mental health records back and forth between the health clinic and the mental health bungalow. Counselors worried that charts would be misplaced or would be read by students or unauthorized adults. Now, all medical records remain at the clinic and counselors keep case notes on separate clinic note sheets, which are sent to the health center so files can be updated.

Some students reported feeling uncomfortable with the method used for releasing them from class for counseling appointments. Students must present their teachers with a bright orange card that contains their counseling schedule for a signature authorizing their release. Mental health staff acknowledge that a subtler release form would make counseling services more discreet.

Patterns in service use. Increases in staffing and the availability of counseling have increased demand for mental health services; when students feel services are accessible and immediate, they are more likely to seek help. Students with crises or major problems are seen immediately; students with less-pressing problems may wait a week or two for counseling.

Approximately 70 percent of the students who seek counseling are female, and most are Latina. These students often suffer from low self-esteem and acculturation problems. Other frequent users are gay and lesbian students who feel the clinic is their only safe haven. Violence encompasses all of the problems that bring students to the program, especially child abuse and suicidal ideation. Sexual abuse is the most common abuse problem, which raises related issues of empowerment and self-esteem. Gang-related problems include the development of negative support systems; inability to develop trust; exposure to or involvement in extreme violence; Post-Traumatic Stress Disorder; inability to tolerate structure in school and at home; and rebellious attitudes, disruptive behavior, or authority problems. Most gang-involved students also use drugs and alcohol. Most are male, and their machismo inhibits them from seeking or responding easily to intervention.

Organizational/Management Structure

The school clinic is operated by the Northeast Valley Health Corporation (NEVHC), a federally qualified health center and a state-licensed community clinic. NEVHC's school health director, located at the school-based clinic, gives the counseling staff a great deal of autonomy. The health director is available for staff consultations but does not observe counseling sessions; she often sees the counselors and interns informally or talks with them by phone several times a week, and meets with them on a formal basis every few weeks to resolve any issues. The principal meets monthly with clinic and school health staff to discuss problems and strategies.

The lead counselor is in charge of the mental health clinic and supervises the interns. Approximately half of his time is dedicated to providing direct services and half to coordinating the clinic. The lead counselor's responsibilities include helping staff solve ethical dilemmas or choose intervention approaches; coordinating counseling groups; scheduling sessions; maintaining a computerized database of service recipients and services; and conducting counseling groups, interventions, and crisis management. The mental health staff meet with the lead counselor once a week for formal supervision. During this group meeting, the lead counselor assigns new cases, counselors seek input on difficult cases, and staff resolve personal or administrative issues.

The lead counselor also devotes some time to solving "political problems." For example, he interacts with school personnel or parents who are concerned about counseling (e.g., when parents of a gay student think counseling is encouraging homosexuality) or students who feel harassed by school staff. Students frequently ask

mental health staff to help them file complaints addressing insensitivity in classrooms, direct sexual harassment, or inappropriate comments about women or homosexuals. The lead counselor also intervenes on behalf of students who must miss class regularly to receive counseling.

Staffing

The counseling staff consists of (1) an 80-percent-time marriage/family/child (MFC) counselor, whose salary is paid partly by the mental health grant and partly by the school-based clinic; (2) a half-time MFC counselor, hired specifically by the grant; (3) a consulting psychologist, who works four hours a week; and (4) seven interns who are working on counseling or psychology degrees at local universities and work 10-15 hours a week at the high school. The director of school health services at the health center also contributes some time to the project for administrative oversight. The lead counselor supervises the half-time counselor and interns. The consulting psychologist also serves as a preceptor for the interns.

The interns provide an affordable means of expanding the number of counseling hours available. The interns's presence also enables group session leaders to include counselors of both genders, which makes it easier for some students to share their personal problems. Interns carry significant case loads; one experienced intern counsels approximately 100 students, and the others average about 50 students.

Staff are chosen for their cultural sensitivity and for their ability to deal with the unpredictability of adolescents and the space limitations. "They're not going to have a private office and free time to write up notes on cases; it's not quiet," warned the school health director.

The project has benefitted from an expanded staff. "We almost always have someone available who's not seeing someone at that moment. Before, sometimes everything would get backed up," the school health director said. In addition, the clinic's nurse practitioner now has more time to devote to medical services instead of mental health care.

Integration and Coordination

When the health clinic first entered the school, health providers did not seek integration with the school; health practitioners viewed themselves as a separate entity. Over time, the clinic learned that there were benefits in coordinating health and education services. For example, having the same main entrance for the health clinic and the school nurse's office removed the stigma of visiting the clinic; so did the practice of placing the IMPACT office, the school psychologist, and the mental health clinic in the same bungalow. And the school nurse proved valuable in helping the clinics obtain parental consent for services during student registration.

Now, mental health staff visit health education classrooms two times a year to talk about the clinic and mental health services and to distribute consent forms to students. Project staff make themselves available in the faculty lounge and reach out to teachers informally so they feel comfortable approaching clinic staff. The clinic's consulting psychologist also helped school staff create a collaborative crisis team to address incidents on campus. Members included faculty, administrators, and service providers. The team disbanded when the vice principal who facilitated meetings transferred to another school, and as violence abated, but the group may be revived. Mental health staff say the crisis team helped bridge the communication gap between the clinic and school.

The mental health clinic also coordinates with IMPACT, and the two entities make co-referrals. IMPACT, staffed by specially trained teachers who receive a stipend, is designed to meet the basic needs of students to enable them

to function in school. IMPACT primarily addresses drug and alcohol problems and grief issues and plans to begin a group session on gang-related issues; counseling sessions are viewed as "rap groups" rather than therapy sessions. The mental health clinic deals with students' deeper emotional and clinical problems, such as abuse or suicidal tendencies. Coordination with IMPACT (1) gives the mental health clinic a place in the school that teachers can understand; (2) reduces the burden of treating high numbers of students for both mental health and IMPACT staff; (3) enables the mental health counselors to reach some students without parental consent, through joint counseling arrangements; and (4) enables mental health counselors to inform teachers of the clinic's services through presentations during IMPACT's teacher orientation workshops.

Although clinic and counseling staff say they have generally full support from the school, a few teachers have resisted having students pulled out of class. One counselor recalled a teacher who, when given a release request for a student in counseling, crumpled the summons and threw it away. Resistance to pull-outs has increased along with the number of students receiving counseling. Careful scheduling of counseling groups so that students miss the same class only once a month, and limiting students to participation in no more than two groups, reduces teacher resistance. In extreme cases, counselors will reschedule a student's sessions.

The counseling project does not impinge on the turf of the school psychologist, who conducts special-education testing but not mental health counseling. The project is still working out coordination with the school nurse, however, who is new to the school. To show that the clinic and mental health services can take some burdens off the school nurse, clinic staff allow the nurse to use the clinic's copying machine, and they keep track of her immunization records for her. "It's the little things that help—like, 'You can put your lunch in our refrigerator if we can use your typewriter,'" an administrator observed.

At the district level, the school-based health clinic and mental health component benefit from a positive relationship with the district liaison for school-based health services. The liaison helps secure funding for the project, assists in public relations, and negotiates with the district for more space for clinic services. The clinic director sees the liaison as a valuable resource and an important link to the school district.

Faculty training. The mental health clinic collaborates with IMPACT to conduct in-service teacher training and to bring in outside speakers for presentations on the need for mental health services on campus. Once a year, IMPACT convenes teachers in groups of 30 to explain referral procedures and have students share stories of their experiences with counseling. IMPACT also assembles the entire faculty once a year for a day-long meeting on mental health services and violence prevention. The clinic's lead counselor participates in both forms of faculty development. The clinic also sends thank-you notes to teachers after every referral and holds an annual "thank-you" brunch where teachers who make referrals receive information on clinic services.

Parent, Family, and Community Involvement

The mental health clinic does not conduct any formal outreach to parents, although family counseling sometimes occurs in the course of treating a student's problems. The lead counselor would like to offer parenting classes but parents have not responded. The project has problems with parents once or twice a year, according to the school health director. For example, when one student informed his family that he was gay, his parents accused the mental health worker of making him homosexual.

Cultural Responsiveness

Latino culture generally cultivates privacy and shuns mental health care, which is viewed as a sign of weakness. Latino students may be hesitant to seek counseling or unwilling to share private information with counselors; parents may be reluctant to consent to services or participant in family therapy.

Because most San Fernando students are Latino, and many find it easiest to talk about sensitive issues in their native language, clinic leaders feel it is important to hire health care providers, counselors, and interns who speak Spanish. Finding appropriate staff who are bilingual and can make a long-term commitment has been a struggle because of the school's remote and intimidating location and the relatively low pay scale. Only one intern, the lead counselor, and the consulting psychologist speak Spanish, so the project has found it hard to increase the number of bilingual counseling sessions—although students' bilingual friends sometimes translate during counseling.

Counselors are aware of the problems Latino students face in fitting into the mainstream U.S. culture. Many recent immigrants have parents with very traditional Latin values; these students feel restricted or, among girls, devalued because of their gender. Other students need help in managing the anger they feel at anti-immigrant messages in American culture, or for their personal experiences as objects of racial hatred. Because recent immigrants want desperately to belong—and because many are accustomed to a high level of violence in their lives—some are at risk of joining gangs. Counselors try to talk about the problems of acculturation, develop students' self-esteem, and help these students connect with bilingual agencies or providers outside the school.

Funding and Reimbursement

The school-based clinic's total annual budget is $694,000. The clinic receives $167,000 a year in private contributions, $156,00 in in-kind contributions, and $62,000 from MediCal (the state Medicaid agency) and CHDP (California's version of Early and Periodic Screening, Diagnosis and Treatment) screening reimbursements. Although the clinic does its own billing and receives payment on about 60 percent of claims, MediCal reimbursement is slow to arrive and does not cover the entire expense of services. The expanded mental health/violence prevention project is supported by the grant from the HRSA BPHC. The school district pays for clinic space, utilities, janitorial services, and a half-time clerk located in the nurse's office, but not for the clinic's telephones.

The average cost per encounter at San Fernando's school-based clinic is $79, the lowest of the city's three school-based clinics. However, only about 2 percent of students have insurance (i.e., non-HMO); 68 percent of students have no insurance at all, 15 percent belong to HMOs, and 15 percent are eligible for MediCal. The students eligible for MediCal often have trouble obtaining their identification cards from parents or have restricted coverage.

Some mental health interns receive stipends that range from $150 to $450 a month, based on experience. That expense ($19,000 a year, total) is essential to attracting long-term interns, which provide more continuity of services and thus more effective therapy.

Lack of long-term, stable funding is a significant barrier, especially because so many students are uninsured. "I'm kind of getting to the panic stage," admitted the school health director. "I never thought we would lose this program because it's done such good things... But if we don't have money to do it, we're going to have to go on treating the symptoms." District leaders are also worried about the trend toward managed care, because the state has not defined a role for school-based clinics in the designation of a medical homes and because the students that the clinics serve are unlikely to take a proactive role in choosing their own medical homes.

Implementation Issues, Barriers, and Solutions

Inadequate space presents privacy issues and restricts services. "If we had three more staff people we could fill every hour of their time, but there's not any place to put them," said the school health director. "We've had to be creative. There are times when we can [use] the school counselor's office. We kind of are floating. We also rotate the groups we have." Complicating the problem is the fact that students do not receive counseling at the same time each week. Although the fluctuating schedule ensures that students don't always miss the same class, it makes it harder to obtain free classrooms regularly.

Health and education professionals are sometimes at odds over the importance of mental health services and the effects of counseling. Some health care providers view school bureaucracy as a barrier to coordinated efforts. The school—strained by over-crowding and the threat of gang violence—has an interest in containing student behavior, while mental health workers want students to express themselves and open up their feelings. This conflict of interest is hard for some educators to understand—and the lack of understanding can exacerbate students' problems. "The administration will say you have to get the student back to class ASAP, but his brother just got shot, and making sure he goes to class is the least of my worries," said one counselor. To address this problem, mental health staff constantly communicate with school administrators and teachers on an informal basis to sensitize them to student problems and the need for intervention.

Mental health staff see a need for additional services that the project does not offer but have not figured out how to expand the project without straining its relationship with the school. Topics include gang intervention, employment counseling, and broader outreach to female students to improve health education, self-esteem, and relationships with males. "The problem is... we are already taxing the school's patience by taking kids out of class," a counselor said. "And a lot of kids won't stay after school to deal with problems even if we offer services or groups then."

Accountability and Self-Assessment

The clinic primarily collects process data, using the School Health Online!!! information management system to compile data on client demographics, patient encounters, diagnoses, and referrals. These data are used to generate quarterly reports that are submitted to the school district's coordinator of school-based health clinics and are used on-site for program planning. Although the School Health Online!!! system can generate sophisticated customized reports and track follow-up appointments, staff say that designing special reports can be complicated; the system does not come with staff training; and the standardized formats are constantly changing, so staff must now develop custom reports to collect information they previously collected automatically. A full-time community health worker in the school-based clinic is responsible for data entry and record keeping.

The school district collects the number of mental health encounters and a breakdown of diagnoses, which it uses to attract or justify funding. But despite the advantages of tracking student information, mental health care providers find that as they implement data collection systems it can become harder to evaluate how well they are meeting the needs of students because they are able to identify more needs. For example, clinic staff are more aware of high rates of child abuse because they are able to meet with more students and assess their circumstances. The rate isn't unusually high in San Fernando, the school health director says—it's just that the violence prevention project provides a forum for more students to tell health staff about the abuse. "We're opening up a can of worms," the health director admitted.

Quality assurance is helped by the fact that students rarely see only one mental health provider; the duplication of contact means that counselors are likely to be aware of most of a student's needs. In addition, the lead counselor who assigns students to specific interns or counselors maintains oversight of all students' needs and progress. Once a week, the lead counselor and the consulting psychologist discuss specific cases, therapy approaches, and issues involved in coordinating the health and education systems.

Evidence of Success

The project reports the following accomplishments:

- Waiting time for services has been reduced to less than one week on average; high-risk students can be seen within one or two days, if not immediately.

- Individual counseling hours average 20 hours per week (up from four hours in 1993)

- The client tracking system has increased case management.

- Mental health visits have increased 328 percent in the last three years, from 379 during the first quarter of 1993 to 1,245 during the first quarter of 1995.

- Student referrals to the mental health services have increased.

- Public information on the project has increased, through articles in the campus newspaper and the Los Angeles Times and interaction with the school's peer counseling class.

- The mental health intern program is well established among local psychology and social work schools, resulting in more requests for placement in the project.

- Students receiving counseling gain the skills and confidence to counsel their peers informally and to introduce their friends to mental health services.

The general school atmosphere has improved. Since 1993, there have been no shootings, no "successful" suicides, and no reported fights on campus. As the mental health staff have become known as advocates for students' mental health needs, teachers have become more aware of comments or practices that could be construed as gay-bashing, and the climate for homosexual students has improved slightly. The availability of services on-site has reduced the burden on teachers and school staff who previously felt overwhelmed by their students' multiple needs.

Students are aware that help is available if they need it, and the stigma placed on seeking help has diminished. "Sometimes, talking to mental health staff is the only thing [students] look forward to all day," said one clinic staff member. "And if you have a reason to go to school, you're probably also going to your classes." Students who feel threatened, especially those who are gay or lesbian, view the mental health clinic as a safe haven. Flocks of students descend on the tiny clinic during lunch and snack periods to hang out in a place where they know they will be safe from harassment.

Educators view the violence prevention/ mental health counseling as essential to all students, not just those most at risk. The coordinator of the 480-student magnet program said her students need counseling to deal with the high expectations of the math/science/technology program as well as the violence or family problems that distract them from their studies. The principal also reported examples of high-achieving students who needed counseling to cope with the stress in their lives. Finally, the principal also believes that students who participate in counseling learn valuable conflict resolution skills without knowing it. "It teaches coping skills indirectly," he explained.

For more information about HRSA BPHC school health programs, please contact the school health staff at 301-594-4450.

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